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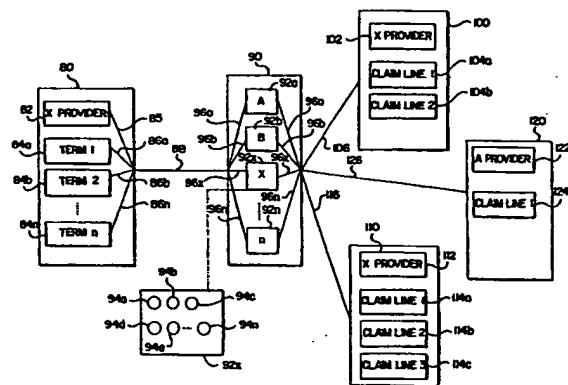
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(54) Title: NOVEL METHOD AND APPARATUS FOR REPRICING A REIMBURSEMENT CLAIM AGAINST A CONTRACT



(57) Abstract: A method for repricing a reimbursement claim under at least one contract is provided herein. The method includes converting each contract into a series of contractual terms, where each contractual term contains qualification codes, calculation codes and priority notes. The method then converts a claim into a series of claim lines, containing claim codes, unit numbers and corresponding charges for the claim codes. The method then begins to compare each claim code, of the claim, against each qualification code, of each contractual term, of a contract and when a qualification code, of a contractual term, is satisfied by a claim code, of a claim line, the method identifies the contractual term as a matching contractual term associated to the claim line. Upon identifying all matching contractual terms, either to the claim line or the entire claim, the method will determine any priority conditions associated to the matching contractual terms, and eliminate any matching contractual terms that are excluded by the priority conditions. The method then calculates the reimbursement amount for the claim by determining the reimbursement charges for the non-excluded matching contractual terms. The method may then determine and make any adjustments depending upon any discount terms for the entire reimbursement amount.

NOVEL METHOD AND APPARATUS FOR
REPRICING A REIMBURSEMENT CLAIM
AGAINST A CONTRACT

5 **Field of the Invention**

This invention relates to a computer method and apparatus for processing and modularizing software, and more particularly, to a method and system for modularizing software for repricing a reimbursement claim against a contract.

10 **Cross Reference to Related Application**

The present application is a continuation of provisional application serial number 60/159,306 filed October 14, 1999.

15 **Background of the Invention**

15 A preferred provider organization (referred to herein as "PPO") is a collection of physicians, hospitals, clinics, etc. (referred to herein as "providers") which have agreed to provide healthcare services to PPO members (such as employers, employees, and consumers, referred to herein as members) at a reduced cost. The individual providers contract with the PPO to provide specific services to the members at a shared cost. It is important to note that a single provider may belong to a number of PPOs. For instance, a cardiologist may belong to two or more hospitals, each hospital having a physician PPO with its doctors. The cardiologist may also belong to a PPO formed by a collection of cardiologists. The PPOs further contract with insurance companies, third party administrators, and employers (referred to herein as "Insurers") in order to share the allocation of risk and cost. Since Insurers can reach a broad area and range of members, the Insurers develop and group numerous PPOs to cover such a broad range.

20 The reimbursement of the healthcare services provided by the providers is designed about a submitted claim system built for point of service insurance. When a provider treats a member, the provider submits a claim, for the services rendered, not to the PPO but to the Insurer for reimbursement thereof. Since, as mentioned above, a single provider contracts with numerous PPOs (with separate contractual arrangements

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for each), and the PPOs then contract with the Insurer, the Insurer must review all governing contracts to determine the proper amount of the reimbursement.

By way of example, a typical claim may include services from multiple doctors for various services performed. For instance, a claim may include services from a Radiologist for \$1,000, an Emergency physician for \$2,000, and an Anesthesiologist for \$3,000. Each physician may have a contract with the PPO or Insurer to pay 100% of their services under \$3000, but the hospital may also have a contract with the PPO stating that submitted claims in excess of \$5000 for a single patient will be repriced at 85% of the charges. If the Insurer reimburses the claim as is, the Insurer has overpaid. Alternatively, if the Insurer reprocesses the claim under the governing contracts and reduces the reimbursements proportionally to each physician (known as "repricing"), the physicians may disagree with the proportionality or the repricing and appeal their reimbursement amount. In order to avoid such repricing by the Insurer, physicians may unbundle the claim into three claims, and submit the three claims separately. The separately submitted claims each receive the total amount of their reimbursement but the Insurer has overpaid.

Since, Insurers may have tens of thousands of separate contracts covering hundreds of thousands of individual providers the ability to review all governing contracts for every submitted claim is extremely time consuming. If the Insurer, however, pays all submitted claims as is, the Insurer will be overpaying. To compensate with overpaying claims Insurers may spot check claims or check every claim. When, however, the Insurer begins accurately checking all claims, reimbursement is significantly delayed. In response to Insurer's delaying reimbursements, laws have been enacted that require Insurers to reimburse claims within a specific period or pay a penalty. As such, Insurers may intentional short each reimbursement, regardless of any governing contracts.

Prior systems or software, which managed contracts, typically viewed the contracts as linear single tier contracts. Each contract was independent of all other contracts. Moreover, if a contract was outdated, replaced or no longer in effect (or if a term within the contract was replaced or no longer in effect) a new contract would be developed from a contract template. The new contract would be added to the end of the

outdated contract, providing the Insurer with a long linear list of contracts, some of which were no longer in effect. In order to determine which contract governed a claim or claim line the Insurer would have to review all contracts, determine which terms governed, the priority of the governing terms and determine if subsequent contracts governed over prior ones. As multi-tiered contracts developed, i.e. one tier governing the provider and the PPO and a second tier governing the PPO and the Insurer, the systems similarly bundled the two contracts end-to-end, into a single tier contract, effectuating the same problems. Since providers now belong to numerous PPOs, numerous contracts are created and the ability to update and manage these contracts has now become extremely difficult. When two or three multi-tiered contracts are bundled into single linear contracts, there is no interaction between the multi-tiered contracts. Consequently, if a provider changed information in one contract, the information would have to be changed throughout all governing contracts or an entirely new contract would have to be created.

As such a need exists for a method and apparatus, which provide the ability to organize, maintain and modify these contracts between the Insurers, the PPOs and the providers. The method and apparatus should be able to create contracts, store generally information globally apart from the terms, such that other contracts and/or claims may share the information. This information which when changed or edited will then be changed throughout each contract or claim. Moreover, since all contracts are governed by pre-defined industry standards, the contracts may now be organized and processed to provide the method and apparatus with the ability to determine which contracts and terms govern a claim, without having to manually search through each contract.

As such, a need also exists to provide the Insurers and PPOs with the ability to determine the correct reimbursement for claims based upon these governing contracts and terms. Moreover, a need exists to provide adequate reasons, based upon these governing contracts, as to why claims were reprocessed. Moreover, the ability to control the data integrity of the contracts and claims is significantly increased. Modifications to contracts are easy and globally done. Additionally, the need exists for a centralized database to maintain and manage the contracts. The ability to electronically submit claims and have the claims repriced through the database would greatly decrease

delays in reprocessing. The PPO or Provider electronically submitting the claim would receive immediately (approximately) the amount of the reimbursement, and the reasons why the claim was repriced.

5 **Summary of the Invention**

10 In accordance with the present invention a method and apparatus provides for the repricing of reimbursement claims against contracts. In an embodiment of the present invention, a method for repricing a reimbursement claim under at least one contract includes converting each contract into a series of contractual terms and
15 converting the claim into a series of claim lines. The method then sequentially compares each claim line against each contractual term of a contract. When a claim line satisfies a contractual term, the method identifies the contractual term as a matching contractual term associated to the claim line. Upon identifying all matching contractual terms, the method will determine any priority conditions associated to the matching contractual
20 terms, and eliminate any matching contractual terms that are excluded by such priority conditions. The method then calculates the reimbursement amount for the claim by determining the reimbursement charges for the non-excluded matching contractual terms. The method may then determine and make any adjustments depending upon any discounts or stop losses for the entire reimbursement amount.

25 In other embodiments, the method would store the reimbursement amount and the repriced claim in a storage location. A second claim being repriced would be compared to other repriced claims to determine if the claims are identical or whether the claims were unbundled from a single claim. If the claims were unbundled, the method would bundle the claims and reprice the bundled claim, replacing any reimbursement
30 amounts for the unbundled claims.

Other embodiments provide for the contracts to be stored within a data center, on a network. The data center stores a plurality of networks, each containing a plurality of contracts. The contracts having specific identifying codes allow the contracts to be sorted in specific networks. The reimbursement claims also containing identifier
35 codes identify which network the claim will be repriced against. Once the network is located the method determines which contract(s), within the network, governs over the

claim. The method would then reprice the claim against the governing contracts. Default settings, or user-defined settings could select the highest or lowest reimbursement value from the governing contracts.

5 Numerous other advantages and features of the invention will become readily apparent from the following detailed description of the invention and the embodiments thereof, from the claims, and from the accompanying drawings.

Brief Description of the Drawings

10 A fuller understanding of the foregoing may be had by reference to the accompanying drawings, wherein:

Figure 1 is an example of an Administration Window for managing, creating, and maintaining rate sheets;

15 Figure 2 is an example of a Providers window for creating and maintaining information in relation to all of the providers of the rate sheets and reimbursement claims;

Figure 3 is an example of a default window for the rate sheets;

Figure 4 is an example of the calculation categories window with the category Per Diems highlighted;

20 Figure 5 is an example of a claim window used for managing and maintaining the reimbursement claims;

Figure 6a is the top portion of an example of a claim form window used for creating a new reimbursement claim;

Figure 6b and 6c are the bottom portions of Figure 6a;

Figure 7 is an example of a completed claim form;

25 Figure 8 is a block diagram illustrating the inter-relationship between containers, contexts and beans created by the reimbursement platform and the contracts platform in accordance with the present invention;

Figure 9 is an example of a provider contract used to create a rate sheet with the contract platform;

30 Figure 10A is an example of a Rate Sheet window used to maintain and create the rate sheets;

Figure 10B is an example of the Create Rate Sheet window, which is brought about when a user begins to add a new rate sheet;

Figure 10C is an example of the Create Rate Sheet window of Figure 10B when the user has selected the sections, which correspond to the terms of the contract;

5 Figure 11 is an example of the Rate Sheet window showing the rate sheet of Figure 10B prior to adding any terms of the rate sheet;

Figure 12 is an example of the Rate Sheet Terms window used to add and edit the terms of the rate sheet;

10 Figure 12a is an example of the qualifications box, which is part of the Rate Sheet Terms window of Figure 12, used to determine the specific codes within a code range that the term will qualify under;

Figure 12b is an example of the qualifications box of Figure 12, illustrating a few of the different types of pre-defined code groups that are available;

15 Figure 13a is an example of the Rate Sheet Terms window containing information needed to create the Per Diem – Medical term of the contract from Figure 9;

Figure 13b is an example of the Rate Sheet Terms window containing information needed to create the Per Diem – Surgical term of the contract from Figure 9;

Figure 13c is an example of the Rate Sheet window with the terms Per Diem Medical and Surgical added.

20 Figures 14-18 are examples of the Rate Sheet Terms window, each Figure containing information to create a term of the contract from Figure 9;

Figures 19A & 19B are the top and bottom screens from the Rate Sheet window containing all of the terms from the contract of Figure 9;

Figure 20 is a hardcopy representation of Figures 19A & 19B;

25 Figure 21 is a block diagram illustrating a Rate Sheet and a Claim;

Figure 22 is a flow diagram illustrating the processing flow used to organize the pre-defined sections;

Figure 23 is a flow diagram illustrating a sub-processing flow used to reprice a claim;

Figure 24 is a repricing worksheet window displaying information in relation to the repricing of the claim illustrated in Figure 7 against the rate sheet illustrated in Figure 20;

Figures 25a and 25b are split screen window depicted a second claim;

5 Figure 26 is a repricing worksheet window displaying information in relation to the repricing of the claim illustrated in Figures 25a and 25b against the rate sheet illustrated in Figure 20; and

Figure 27 is a block diagram illustrating an embodiment managing and maintain various networks on a data center that contain rate sheets for repricing claims.

Detailed Description of the Drawings

10 While the invention is susceptible to embodiments in many different forms, there are shown in the drawings and will be described herein, in detail, the preferred embodiments of the present invention. It should be understood, however, that the present disclosure is to be considered an exemplification of the principles of the invention and is not intended to limit the spirit or scope of the invention and/or claims of the embodiments illustrated.

A. Overview

20 Medical contracts entered between PPOs, Providers and Insurers, and reimbursement claims, submitted by the PPOs or Provider to the Insurers, utilize standards driven and created by the industry in order to maintain a single continuity throughout the industry. Typically, an Insurer receiving a reimbursement claim would manually reprice or reprocess the claim. Contracts and claims maintained and stored by
25 systems, in the prior art, were done simply to store the information, not to actually reprice or reprocess the claim. The standards, discussed in greater detail below, allow for the contracts and claims to be broken or torn down into standard pre-defined, as well as user defined, contract terms and claim lines. Once broken down, these contract terms may be organized and sorted to provide a repricing flow, which can be applied to virtually all-
30 medical contracts. The claim lines may now be "bounced" against governing contracts to determine the proper amount of the reimbursement.

In the preferred embodiment, an input and output device, such as a mouse, for "clicking" or selecting graphic elements as well as a keyboard for inputting and editing, are used to manage and maintain the contracts and reimbursement claims. The system using a contract platform, such as Resource Information Management Systems Inc.'s NetworX™ Administration software, provides a user with the means to create and manage contracts. The contract platform may be separate and apart from a platform used to create, manage and reprocess reimbursement claims, referred to herein as a reimbursement platform. The reimbursement platform, such as Resource Information Management Systems Inc.'s Manual Claim Entry 1.2.6.1 software, allows the Insurer to create reimbursement claims and reprice the claims by bouncing the claims against the contracts managed by the NetworX™ Administration software. The two platforms while preferably separate platforms may be combined into a single platform.

The reimbursement platform preferably permits the Insurer to manually create or enter the reimbursement claims and designed to accept the reimbursement claims through various communication mediums. Reimbursement claims received through various communication mediums, such as digital or electronic transfers, would speed up the reprocessing of the claims.

Preferably the contract terms and claim lines are gathered, by the above mentioned platforms, and stored individually as specific types of beans, discussed in greater detail below. The platforms are created using reusable software components, which can be used with a software development environment. Software development environments can integrate visual and source views of the components through use of certain features such as, for example, drag-and-drop. The drag-and-drop feature allows a software developer to modify the property values associated with the graphic user interface or "GUI" component while simultaneously viewing the modifications to provide the user with a type of virtual processing. The virtual processing pattern removes the dependence between components, because components at all levels have very little interdependence between inner components. It makes the systems easier to modify and upgrade, such that individual components may be replaced rather than replacing entire products. These components may be downloaded and installed using standard Internet technologies.

Illustration figures used throughout represent a general overview of the graphical user interface for the windows and features used by the contract platform and the reimbursement platform. The illustrations used throughout are for example only and are not used to limit or restrict the scope of the claims or the invention.

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B. Contracts Platform

The contract platform, as mentioned above, provides the ability to create, maintain and manage contracts (also referred to herein as “rate sheets”) between the PPOs, Providers, and Insurers. Each rate sheet includes terms, created and stored independently of each other, providing the means to edit and change the terms separately. Moreover, data shared by both the contract platform and the reimbursement platform, for instance, provider or PPO identification data, is stored globally separately from the two platforms, permitting access to such data from either platform. This provides a dynamic inter-relationship among the platforms and the data maintained and managed by both of the platforms.

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Figure 1 illustrates an example of a Main Administration screen 10, which permits the user to build, manage, code, route and maintain the rate sheets. Various tabs 12 are included to help assist the user accomplish these aforementioned functions and are listed across the top of the Main Administration screen 10. The tabs 12 further permit the user to access the pre-loaded industry standards, mentioned above, and to sort, group, and define new standards. These tabs 12, discussed in greater detail below, include, but are not limited to, Roles 12a, Users 12b, Providers 12c, RateSheets 12d, Calculation Categories 12e, Code Groups 12f, Routing Rules 12g, and Mailboxes 12h.

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The Roles tab 12a allows a user to define and manage security access levels for various groups of personnel employed by the user. An Insurer using the platform may have numerous personnel groups that separately access, maintain, edit and enter the information stored by the platforms. The Roles tab 12a allows the Insurer to define the level of access for each group. For example, since contract data entry personnel typically only need access to read/write/delete information regarding rate sheets on the contract platform, access to the reimbursement platform would be restricted. The Roles tab 12a, for security reasons, would typically only be available for a platform

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administrator. The platform administrator would define the level of access utilizing the Roles tab 12a and assign individual security logins and passwords to each personnel, using the Users tab 12b.

5 The Providers tab 12c allows the user to manage information on each Provider. Illustrated in Figure 2, a Provider window 20 permits the user to enter identifying data such as the Provider's tax id, address, zip, a user defined provider code and aliases.

10 When selecting the RateSheets tab 12d, shown in Figure 1, a rate sheet window 30 opens, illustrated in Figure 3. The rate sheet window 30 permits the user to create and manage the rate sheets. The bottom of the window contains a series of tools that provide the user with the ability to create and manage rate sheets and terms. The tools used for maintaining and creating rate sheets are Add Sheet 32a, Change Sheet 32b, Delete Sheet 32c and Cop Sheet 32d. While additional tools are used for maintaining and creating the terms of each rate sheet, such as Add Item 32e (or add term), Change Item 15 32f, Delete Item 32g and Copy Item 32h.

20 The Calculation Categories tab 12e opens a category window 40 and a calculation window 45, illustrated in Figure 4. The calculation and category windows permit the user to organize and select repricing calculations for use under each category. Initially each category contains a list of pre-defined repricing calculations, which are used when creating rate terms. The user however, may further define under each category specific calculations that will be available for use when creating or editing the terms. For instance, if each rate sheet created for an Insurer only includes single level per diem calculations then the per diem category can be adjusted, using the calculation and category windows, to only allow for this calculation. As such, when entering new per 25 diem contract terms, the only calculation available would be the single level per diem.

30 The Code Groups tab 12f, provides the user with the ability to maintain groupings of qualifying pre-defined codes. When entering in a rate sheet, each contract term is defined under a sub-section headings, for instance, Medical and ICU/CCU/NICU. Code grouping permits the user to define which codes qualify for repricing under these sub-sections. For example, when using revenue codes, the industry has determined that revenue codes 120-123 define procedures under a Medical sub-section, while the revenue

codes 174, and 200-219 define procedures under the ICU/CCU/NICU sub-section. The pre-defined codes include age, ICD9 procedure and diagnosis codes, DRG codes, CPT-4 codes, revenue codes, and Provider groups (such as Surgeon, Assistant Surgeon, and Anesthesiologist). Under the code groups tab 12f the pre-defined code groups may be adjusted or new groups may be created to cover specific terms in a rate sheet.

The Routing Rules tab 12g is used to establish which mailbox, created using the Mailbox tab 12h, the reimbursement claims are routed to. For instance, after a data entry personnel enters claims into the reimbursement platform, the system may save the entered claim and route the claim, using defined routing rules, to a repricing mailbox. A second personnel may thereafter, open the repricing mailbox, retrieve the claim and reprice the claim.

C. Claim Reimbursement Platform

As mentioned above, the claim reimbursement platform is used to manage and maintain the claims. The user may create, edit and reprice the claims against the rate sheets utilizing the tools provided by the reimbursement platform. As illustrated in Figure 5 a graphic representation of the reimbursement platform is shown in a claim window 50. A toolbox 52 located along the top of the claim window 50 contains various tools, graphically represented. The tools include, but are not limited to the following, Creating New Claims 52a, Repricing Claims 52b, Route Claims 52c, and Display Repricing Details 52d. Similar to the Routing Rules tab 14g, the Insurer may route the claims to various predefined groups or mailboxes (created under the mailbox tab 12g) by using the Route Claims tool 52c.

Illustrated in Figures 6a, 6b and 6c, when a new claim is to be created a new claim form window 60 is opened. Using the input devices mentioned above, a user enters in a claim, to be repriced. Figure 7 illustrates a claim 70 that has been created and saved in the system and is awaiting to be repriced. As illustrated the claim contains several claim lines, rows 72a, 72b, 72c, 72d. Listed in each row are specific revenue codes, column 74a, general descriptions of the codes, column 74b, the number of units of each code, column 74c, and the total charges, column 74d, and etc.

As mentioned above, since information is stored as beans, the information is easily shared and used by both platforms. As such, the provider beans used by the contract platform may be used and linked to claims created on the reimbursement platform, such as the information identifying a provider entered in boxes 76a-76e, Figure 7. By way of example and as illustrated in Figure 8, a completed contract, between Provider X and the Insurer, may be stored on the system as a RateSheet context 80. Contained within the RateSheet context 80 may be a provider container 82 identifying the provider of the RateSheet as X provider. Also included within the RateSheet context 80 are term containers 84a...84n representing n terms of the contract. The RateSheet context 80, as well as the other containers within, includes logic 85 and 86a...n that links to the other contexts and/or beans contained within or stored globally, logic link 88.

While the information identifying X provider (i.e., Provider Code, zip, city, state, address, etc.) may be stored in the provider container 82 of RateSheet context 80, it is preferably stored in a Provider context 90. The provider context 90 has stored within containers corresponding to the providers, represented as container 92a corresponding to A provider; container 92b corresponding to B provider;...; container 92x corresponding to the X provider;...; 92n container corresponding to n provider; each container housing identifying beans that represent the provider's information. Closely examining the container 92x, which stores identifying information in relation to the X provider, the container includes identifying beans 94a...94n. Each identifying bean represents a single piece of information regarding the X provider, for instance, bean 94a may represent X provider's zip code. As with the RateSheet context 80, the provider context includes logic links 96a...96n to the provider containers stored within.

Also illustrated in Figure 8, is three claim contexts, a first, second and third, 100, 110 and 120 respectively. The first and second claim contexts 100 and 110 represent claims submitted by the X provider and the third claim context 120 represents a claim submitted by A provider. As illustrated the first claim context 100 includes a provider container 102, identifying X provider, and 2 claim containers 104a and 104b, which store information in relation to the claim lines; the second claim context 110 has a provider context 112, identifying X provider, and includes 3 claim containers 114a, 114b and 114c; the third claim context 120 has a provider container 122, identifying A

provider, and a claim container 124a. Moreover, each claim context contains links 106, 116, 126 to the provider context 90, respectively. Since the provider information is stored within provider context 90, when the information is changed, each context that is linked thereto is automatically updated. Therefore, if the zip code, bean 94a, of X provider is changed while entering the second claim 110, the provider container 102 of the first claim context 100 and the provider container 82 of the RateSheet context 80 is automatically updated.

This permits multi-level interaction between contracts and reimbursement claims. Tens of thousands of contracts relating to hundreds of thousands of PPOs may be managed and organized within seconds, instead for hours. Moreover, and as described in greater detail below, the reimbursements claims may be bounced off of all of the stored contracts, to determine all governing contracts more quickly and more efficiently than prior systems.

D. Rate Sheet or Contract Creation Example

In this example, a simple Provider Contract 140, as shown in Figure 9, is converted to a "Completed Rate Sheet" 200, shown as split screens in Figures 19a and 19b. As shown in Figure 9 the Provider Contract 150 between a Medical Center and an Insurer for medical reimbursement claims contains various terms. As provided, the Provider Contract 150 defines the following terms: Medical per diem cost at \$750.00; Surgical per diem cost at \$950.00; Normal Delivery at \$1,400.00 for 1-2 day stay case rate with an additional \$450.00 charge for each additional day; Cesarean Section at \$2,800.00 for 1-2 day stay case rate and \$500.00 for each additional day; all other covered Inpatient Services and all Outpatient Services will be discounted at 15% from billed charges; and a Stop Loss for any case in which charges exceed \$20,000 the Medical Center will be paid 85% of the total billed charges.

As mentioned above, the contract is broken down into its terms and stored as term contexts (as in Figure 8). Each term context includes qualification, calculation, and priority beans. For example, the first term "Medical per diem cost at \$750.00," includes qualification contexts which include qualification beans to the code grouping 'medical'; and the category or section 'Per Diem'. A calculation context would include

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Before repricing a reimbursement claim, a user must create a rate sheet. A Rate Sheet 200, such as shown in Figures 19a and 19b, was created using the contract platform, mentioned above, and using as a template the Provider contract 140, from Figure 9.

To create the Rate Sheet 200 a user begins by clicking the RateSheets tab 12d on the Main Administration screen 10, shown in Figure 1, which opens the rate sheet window 30, illustrated in Figure 3. The user then selects the Add Sheet 32a tool, which opens a Create Rate Sheet window 150, illustrated in Figure 10a. Information regarding the provider and the contract is entered in this screen. For instance, a rate sheet code specifically associated to a rate sheet is entered in a code box 152. This permits the user to recall specific rate sheets quickly and more efficiently. The identification or name of the provider is entered in the Rate Sheet Description box 154 and the effective dates of the contract may be entered in the date boxes 155a and 155b. Moreover, if this rate sheet is a subset of another rate sheet the user may select the sub-rate sheet box 156.

In the preferred embodiment, the terms of the rate sheet are organized or listed under pre-defined sections. These sections include Outpatient Exclusions, Outpatient Per Diem, Outpatient Case Rates, Outpatient Services, Outpatient Stop Loss, Per Diem, Case Rate, Exclusion, Inpatient Services, Stop Loss and Professional/Other Services and are listed in an available sections box 158a. Moreover, since the contractual terms categorize within pre-defined sections, a flow process in which reimbursement claims can be processed and repriced may be developed, discussed in further detail below. When a rate sheet contains a term categorized under a pre-defined section, that pre-defined section is selected and added to the selected sections box 158b. When all of the pre-defined sections are selected, the OK button 159 is depressed. As illustrated in Figure 10b, the user adds to the selected sections box 158b the Per Diem, Case Rate,

Outpatient Services and Stop Loss sections, which correspond to the terms in the Provider Contract 140.

Once the OK button 159 is depressed, a rate sheet window 160 opens illustrated in Figure 11. The rate sheet window 160 separates into a title box 162, an outline box 164 and the rate sheet box 166. The title box 162 lists the rate sheet code, the dates in which the rate sheet is valid through and contains a rate sheet search button 168. The rate sheet search button 168 permits the user to search and locate a different rate sheet. The rate sheet box 166 graphically represents the rate sheet as entered and stored by the contract platform, as well as lists the footnotes, discussed in greater detail below. As illustrated, no terms are listed under the sections since the terms have not yet been entered. The outline box 164 only lists the section and subsection headings listed in the rate sheet box 166.

2. Creating Terms

The user may now begin to enter in the terms of the contract. When no terms exist, as illustrated in Figure 11, the user may highlight one of the pre-defined sections, in either the outline box 164 or the rate sheet box 166, and click the Add Item button 152e. If, however, a section contains terms, and a new term is to be added, the user would highlight the term, in which the new term is to follow, and then click the Add Item button 152e. This opens a Rate Sheet Terms window 170, illustrated in Figure 12. The Rate Sheet Terms window 170 has four sub-windows a description window 172, a qualifications window 174, a calculation window 176 and a lower window 178.

The description window 172 assists the user in defining the term. The description of the term or heading is entered in description box 172b and the effective dates of the term, which may be different then the contract, may be entered into date boxes 172c and 172d. Included within the description window 172 is also a heading box 172a, which is selected when the description, in description box 172b, is a note to clarify the term or condition.

The qualification window 174 permits the user to select the type of codes associated to the term and the value of the codes. As mentioned above, the pre-defined codes types, selected from code type pull down menu 174c includes, for example, ICD9 procedure and diagnosis codes, DRG codes, CPT-4 codes, revenue codes, etc. When

using a specific range of codes, the code value box 174a is selected. The user then enters in a range of code values in the value range boxes 175a and 175b, illustrated in Figure 12a. When, however, the code grouping box 176 is selected, the user selects the code group from a pre-defined group of codes from a drop-down menu 177, illustrated in Figure 12b.

The calculation window 176, Figure 12, allows the user to select which calculation to use for repricing a claim or claim line, when that claim line satisfies the criteria defined in the qualification box 174. The user may select from any calculation listed under the various categories defined in the calculation box 176. As mentioned above, the calculations available may be limited under the calculation categories tab 12e, illustrated in Figure 4. The calculation window 176 also includes a complete box 176b. When a term is a final repricing within a section then the user may select the complete box 176b. This prevents the repricing of a qualifying claim line under another term within that section, however, it does not prevent the repricing of the qualifying claim line under another section. If the complete box 176b is unchecked, the system will continue to search through the rest of the terms within the section and may reprice the claim using a different term.

Preferably, the amounts, days and percentages of each calculation are user-defined in order to customize the calculation for each term. For example, a surgical single level per diem charge in a rate sheet may include: "a surgical charge of \$950 a day." In this instance, only the amount of the charge is modifiable. To change this term to for instance, "a surgical charge of \$950 for the first 2 days and \$500 thereafter" the category must be changed to a 2 level per diem charge. The pre-loaded categories include, but are not limited to, allowed, maximum allowed, cost, percentage, discount, per diem, unit, case rate, DRG (diagnosis related groups), reasonable and customary, schedule, stop loss and no calculations.

Illustrated in Figure 13a and in accordance with the Provider contract 140 the first term, "Medical Per Diem repriced at \$750.00 a day," has been entered. As illustrated, the description window 182 contains information in relation to the term. The description box 182a contains the term "Medical" and within the date boxes 182b and 182c are effective dates. The qualifications window 184 indicates that this term uses

code grouping by selecting the code grouping box 184a. The type of codes selected in the code type box 184c is revenue codes with the pre-defined code group being "Per-Diem – Medical," defined in the code group pull down menu 184b. The calculation window 186 indicates that the calculation assigned to this term is a single level per diem calculation. Upon selecting a calculation from the calculation window 186 the system generates and displays each calculation as an English language paragraph in the lower window 188 with a series of calculation boxes 188a interspersed in the paragraph. The user enters in a price of "\$750.00" in the per diem calculation box 188a. Lastly, the user defines the priority of this term in comparison to other terms defined under the Per Diem section. This is accomplished by selecting a pair of priority notes, or footnotes, from the footnote pull down windows 189a and 189b, discussed in further detail below.

When the term is complete, the user clicks the OK button 190. The system will then convert the entered information into beans and store the beans in a container. As illustrated in Figure 9, the container may be stored in a rate sheet context, which contains a plurality of containers, each storing information in relation to a specific term. This permits the user to change, edit, add and delete terms without having to retype or recreate a new rate sheet, only the specific bean or container has to be changed.

Referring now to Figure 13b, the second term "Surgical at \$950.00 a day" from the Provider contract 140 is entered in rate sheet term window 190. As in the Medical term Figure 13a, the Surgical term uses revenue codes, in code type box 192a and the pre-defined code group "Per-Diem – Surgical" defined in the code group pull down menu 192b. In this instance the revenue codes overlap, the pre-defined revenue codes for both Per-Diem Medical and Surgical terms include the codes 110-113 and 120-123. During the repricing process, claims with a revenue code of 111 for example, will qualify for both the Medical and Surgical terms. Since the Surgical term is listed last in the Per-Diem section all claims with overlapping revenue codes reprice at the Surgical rate of "\$950.00", defined in calculation box 192c. One way to differentiate a surgical service from medical care is by the presence of an ICD9 procedure code on the claim. To build the Surgical term with both the revenue code and an ICD9 procedure code is to add a subrate sheet marked in a subrate sheets box 194. The subrate sheet allows for the creation of more than one qualifier, e.g. a revenue code qualifier and an ICD9 procedure

code qualifier. During the repricing process, all claims with an overlapping revenue code and no ICD9 procedure code reprice with the Medical term, while all claims with an overlapping revenue code and an ICD9 procedure code reprice with the Surgical term. As illustrate in Figure 13c, the rate sheet window 195 now contains the two subsections, Medical and Surgical under the section Per Diem. The system, using the beans entered from the rate sheet term window, generates and displays each term as a paragraph.

Illustrated in Figures 14-18 the remaining terms are entered into the Rate Sheet. As shown, the system generates and displays in the lower window different paragraphs depending upon the calculations chosen in the calculation window. For instance, in specific reference to Figure 14, when the calculation "Case Rate plus Per Diem, Limited by Charge" was selected, corresponding calculation boxes, 197a, 197b, 197c and 197d become available to the user. Similarly, this is illustrated in Figures 15-18. As shown in Figures 19a and 19b the completed Rate Sheet 200 shows each section with subsections defining the terms of the Provider contract 140. Similarly, illustrated in Figure 20, the completed Rate Sheet 200 is displayed as a hardcopy printout.

E. Priority Footnotes

As mentioned above, each term has a pair of corresponding footnotes or priority notes, shown in Figure 20. The footnotes associate the priority of a term within a section only, and not the entire rate sheet. Moreover, each term includes at least two priority notes, one priority note is included from a first set and a second priority note is included from a second set. The first set of priority notes includes: (1) this calculation will be used to reprice the entire claim; (2) this calculation will be used to reprice the current line (or claim term) and (3) this calculation will be used to reprice the matching line as a group. The second set of priority notes includes: (4) when the claim qualifies for more than one term, this price will be used if it is the smallest amount; (5) when the claim qualifies for more than one term, this price will be used if it is the largest amount; and (6) when the claim qualifies for more than one term, this price will be used if it is the last term to qualify. Moreover, if the complete box 176b illustrated in Figure 12 is selected a seventh priority note is attached to the term, (7) no more terms will be examined for this claim/line if it qualifies under these terms.

The first set of priority notes, relating to (1), (2) and (3) listed above define how a calculation in the rate sheet 220 will be applied to the claim 210. The first priority note states that if a contractual term applies to a claim line, then the corresponding calculation will be used against the entire claim not just the claim line. For instance, Per Diem and Case Rate Sections will typically reprice the entire claim because all claim lines or services listed in a claim will be in relation to the per diem or case rate procedure. The second priority note "this calculation will be used to reprice the current line" reprices only claim lines that have specific code values that match the codes defined under the qualifications. Under this priority note, the calculation container associated to a qualifying or matching contractual term would apply to the matching claim line only. For example, when a claim contains only various inpatient services, only the qualifying claim lines will be subject to repricing under an inpatient service section, the other non-qualifying claim lines will not be repriced. The third priority note "this calculation will be used to reprice the claim line as a group" will apply a calculation to a group of claim lines. When a claim line qualifies under a term that includes the third priority note, the repricing engine continues to check other claim lines. If the repricing engine matches additional claim lines under the same term, the claim lines are grouped together and repriced one under the term's associated calculation.

The second set of priority notes, (4), (5) and (6) define the priority of the terms within each pre-defined section. Under each priority note, the repricing engine will determine whether a claim line qualifies under more than one term listed under a section. When a claim line qualifies under a term listed in a section, the repricing engine automatically checks the other terms listed in the section. When the claim line qualifies under one than one term, the repricing engine will, according to the (4) and (5) priority notes, calculate a reimbursement amount for each matching or qualifying term. When a matching term includes the fourth priority note "...this price will be used if it is the smallest amount," the repricing engine begins to compare the reimbursement amount for each matching term. The repricing engine then will reprice the entire claim, claim line or group of lines (depending upon the first set of priority notes) under the term with the fourth priority note when the reimbursement amount for this term is the smallest amount when compared to the other reimbursement amounts. Similarly, the repricing engine will

reprice under a term associated to the fifth priority note "...this price will be used if it is the largest amount," when the reimbursement amount for this term is the largest amount when compared to the other reimbursement amounts. If a matching term is associated to the sixth priority note "...this price will be used if it is the last term to qualify," the repricing engine does not need to calculate the reimbursement amounts for each qualifying or matching term. The repricing engine only needs to determine which matching term is the last term in the section and then determine the reimbursement amount for such last term.

As mentioned above, the seventh priority note "no more terms will be examined for this claim/line if it qualifies under these terms" is assigned to terms in which the complete box 176b illustrated in Figure 12 is selected. As such, when a claim line applies under a term with a seventh priority note associated therewith, the repricing engine does not have to search other terms in the section to determine if any more within the section apply.

F. Repricing against the Priority Notes

For further explanation of the priority notes, reference is made to Figure 21, a claim context 210 created using the reimbursement platform has four claim lines 212, 214, 216 and 218 respectively. Each claim line contains claim beans storing information in relation to the claim line, for instance, the revenue code, bean 212a, the number of units 212b, the submitted charge 212c, etc. Moreover, a RateSheet 220 associated to the Rate Sheet 200, illustrated in Figure 20 contains five sections a first section 222, a second section 224, a third section 226, a fourth section 228 and a fifth section 229. The first section 222 (corresponding to the Inpatient Per Diem section in Rate Sheet 200) contains a 1st term context 222a (corresponding to the Medical term) and a 2nd term context 222b (corresponding to the Surgical term). The second section 224 (corresponding to the Inpatient Case Rate section) contains a 3rd term context 224a (Normal Delivery term) and a 4th term context 224b (C-section term). The third section 226 (Inpatient Services section) contains a 5th term context 226a (All Other Inpatient Services term). The fourth section 228 (Outpatient Services section) contains a 6th term context 228a (All Other Outpatient Services term) and the fifth section 229 (Stop Loss

section) contains a 7th term context 229a (Stop Loss term). Moreover, each term context contains a plurality of containers that store a plurality of beans relating to the description, qualification, priority and calculations of the term. For example, the 1st term context 222a has a plurality of containers, a description container 230, a qualification container 232, a category container 234, a calculation container 236, a plurality container 238, as well as a hierarchy container 240. Each container may also store a plurality of beans; for instance, the description container 230 may have three beans, a heading bean 230a and two date beans 230b and 230c. As mentioned above, each container and each bean may be accessed and changed independent of the other containers and beans.

As illustrated in Figure 20 and in correlation to Figure 21, the second section 224 (Inpatient Case Rate section) includes the 3rd and 4th terms 224a and 224b respectively (corresponding to the Normal Delivery term and the C-section term respectively). Each term contains a plurality container with the second and sixth priority notes. As such when repricing for instance the claim context 210 against the RateSheet 220 the repricing engine begins to compare each claim line against each term. If the line one 212 qualifies under the 3rd term 224a then because the 3rd term includes the sixth priority note the repricing engine will continue to check the 4th term 224b, to determine if the 4th term also matches. If the 4th term 224b does match then the repricing engine will reprice the entire claim context 210 under the 4th term 224b because the 4th term includes the first priority note "...used to reprice the entire claim." If the 4th term 224b does not match then the repricing engine will reprice the entire claim context 210 under the 3rd term 224b, because the 3rd term includes the first priority note. Similarly, if while repricing claim context 210, claim line one 212 matches the 5th term 226a (All other Outpatient Services term), the repricing engine will reprice only line one 212, because the 5th term 226a includes the second priority note "...used to reprice the current line.) The repricing engine however, will continue to compare the other claim lines to determine if the other claim lines qualify under another term. As such, if line two 214 qualified under the 4th term 224b, the repricing engine would reprice the entire claim and reprice the reimbursement amount for line one 212 with the reimbursement amount for the entire claim.

G. Claim Repricing against RateSheets

In order to ensure that each claim is processed uniformly under any given rate sheet the contract platform attaches priority conditions to the available predefined sections, mentioned above. Figure 22, illustrates a flow diagram, representing the processing flow the repricing engine uses in organizing the predefined sections for the repricing of a claim.

Starting with step 250, the method may begin by excluded any claim codes from the claim that are substantially equal to any codes listed in the exclusion sections of the rate sheet, step 252. These codes are temporarily excluded from the repricing of the entire claim, and are added back to the claim after the claim has been repriced, step 286. Following step 252, the method then continues to determine the nature of the service, for instance the amount of days and/or the quality of care, step 254. This provides the method with the ability to process the claim under the correct amount of days. Next in step 256, the method analyzes the claim under the Case Rate section. The method sequentially compares the claim codes and determines if the any of the claim codes substantially equal any of the codes defined in the contractual terms listed in the case rate section. If a claim codes falls under the case rate section of the rate sheet the method determines the type of service, whether the claim codes qualifies as an outpatient or inpatient, step 258. The method then determines which term(s) apply, step 260, by determining the priority of the terms. Since terms defined under the case rates section are applied to the entire claim, the method, based upon the qualifying term(s), will reprice the entire claim, step 262.

Following step 256, if the claim codes do not match the codes defined under the terms of the case rate section, then the method determines if the claim line qualifies under the Per Diem section, step 264. If a claim line (containing a claim code) is substantially equal to the codes listed under the Per Diem section, the method determines whether the claim codes qualify as outpatient or inpatient, step 266. Next in step 268, the method determines which term(s) within the Per Diem sections apply and then reprices the claim line based upon the applicable term(s), step 270. If the claim line does not equal any of the codes, step 264, the method will continue to check the other claim lines, step 272, until the entire claim has been reviewed.

When the entire claim has been checked, and none of the claim lines, contain codes that substantially equal the Per Diem rate sheet codes, the method continues to sequentially compare the claim lines to the terms defined under the Service section, step 274. If a claim line contains a claim code which falls under the Service sections, the method determines which type of services, inpatient or outpatient, apply, step 276, and then determines which term(s) apply, step 278. Based upon the priority notes and any priority conditions the method reprices the claim line under the applicable term(s), step 280. Next, the method determines if there are any remaining claim lines, step 282, if so the method returns to step 274, and determines if the claim line can be repriced under the service code. If, following step 274, a claim line does not match any service code the method will error, step 284, because the claim code did not match any code on the rate sheet. Under this circumstance, the claim would probably be forwarded to a mailbox according to the routing rules, previously mentioned.

Following steps 262, 270 and 282, the method adds the excluded lines back to the repriced claim total, step 286. The method continues thereafter to determine if the repriced claim exceeds any stop loss, step 288, defined by the rate sheet. If so, the method reprices the entire amount according to the stop loss, step 290. If the stop loss is not met and following the stop loss repricing, step 290, the method may return, step 292.

H. Claim Repricing Example

Referring now to Figure 23, the repricing engine using this processing flow may begin to reprice claims, for instance repricing the completed claim 70 illustrated in Figure 7 repriced against the Rate Sheet 200 illustrated in Figure 20. As shown in Figure 7, the completed claim 70 includes four claim lines, 72a, 72b, 72c and 72d. Each claim line has a claim code listed in column 74a. As such claim line 72a for Room and Board includes 'claim code 120' and is priced at \$4,000 for 4 units (or four days). Claim line 72b includes 'claim code 350', which represents coronary care, and is priced at \$6,000. Claim line 72c has 'claim code 250', which represents Pharmacy and is priced at \$10,000. Finally, claim line 72d has 'claim code 001' which represents total charges of \$20,000.

When the claim is repriced, the repricing engine, following the processing flow of Figure 22, can logically reprice the completed claim 70. Since there are no exclusions in the Rate Sheet 200 (Figure 20), the method may move to determine the amount of days, step 254. By calculating the units charged in the Room and Board claim line 72a, the method can determine that the amount of days is four. The method then moves to determine which sections in the Rate Sheet 200 apply. Reviewing the Case Rate section, step 256, the method logically determines that the codes listed in the completed claim 70 may not be categorized under neither the Normal Delivery Case Rate or the C-Section Case Rate, Figure 20. As such the method continues, step 264, to determine whether any claim codes qualify under the Per Diem Section. The first claim line 72a, includes a revenue claim code of 120, which falls under the code grouping defined under the Medical term. The method then must determine the type of service provided, inpatient or outpatient, step 266. Since the completed claim 70 included a bill code of '111' in box 71, the method determine that this claim is for inpatient services. If the box 71 included the bill code '112' the method would have determined that the claim was for outpatient services.

Generally the method, determining the nature of the services, will sequentially search all contractual terms listed under the inpatient per diem section and determine which term(s) apply, step 268, also shown in a sub-processing flow diagram of Figure 23. Sequentially analyzing the terms, the method first determines whether the claim line qualifies for repricing under the first contractual term listed under the Per Diem Section, step 268a. If the claim line does qualify the method identifies the term as a matching term and determines any priority conditions associated to the matching term, step 268b. The priority conditions include for instance the priority notes and the hierarchy of the terms listed in the section. Thereafter the method determines if there are any additional contractual terms under the section, step 268c. If there is another contractual term the method return to step 268a. When there are no longer any additional contractual terms, step 268c, the method begins to eliminate matching terms which are excluded by the priority conditions, step 268d. The claim line is then repriced under the non-eliminated matching terms, step 270a, and then the method may return to the processing flow illustrated in Figure 22.

More specifically, and in reference to repricing the completed claim 70 under the Rate Sheet 200, the method determines if the first claim line 72a qualifies under the Medical contract term, the first contractual term, step 268a. Since the claim code, listed in column 74a of the first claim line 72a, of '120' equals a qualification code within the range of the pre-defined Medical revenue codes, the method determines that the claim line qualifies under this contractual term. The method will identify the Medical term as a matching term and will determine any priority conditions. The priority conditions for the Medical term include the priority notes attached thereto. The method continues by determining if additional contractual terms are listed under the Per Diem section, step 268c. Since the Surgical term is also listed under this section, the method will determine if the claim line also qualifies under the Surgical term, return to step 268a. Even though the claim code equals a qualification code within the range of the pre-defined Surgical revenue codes, the claim does not include any CPT4 Procedure codes and therefore the claim line does not qualify under the Surgical term. Since there are no more contractual terms listed under the Per Diem section, the method continue to eliminate any matching terms which are excluded by priority conditions, step 268d. The priority conditions attached to the Medical term include the priority notes: "This calculation will be used to reprice the current line" and "when the claim qualifies for more than one term, this price will be used if it is the last term to qualify." Since the claim only qualified under one term, the method will have no terms to eliminate and will reprice the claim under the Medical term, step 270a. Under the Rate Sheet 200, the claim line would be repriced at \$750.00 a day, multiplied by the four units or days for a total of \$3,000. Returning to step 288, Figure 22, the method would add any excluded claims, which in this example there was none, and determine if the stop loss section applied, step 288. The stop loss term as illustrated will only apply if the total amount of the repriced claim exceeds \$20,000, which it does not, therefore the method may return, step 292.

Under this processing flow, of Figures 22 and 23, the other claim lines would be bundled together under the Medical Per Diem section, such that the prior total of \$20,000 would be subjected to repricing to the new amount of \$3,000. As seen in Figure 24, the nature of the repricing can be graphically displayed in Repricing window 300, which describes that the claim code (revenue code) of 120 represents a Medical Per

Diem charge with four units (days), as such the original charge of \$20,000 was discounted \$17,000 to a repricing of \$3,000.

Even if the claim was unbundled into four separate claims, one claim for each claim line, the repricing engine will identify the four separate claims as originating from the same provided service. By searching the patient, days of care provided, the nature of the care, and the services preformed the repricing engine will identify the four unbundled claims as a single claim, and reprice the group of claims as a single claim. In the alternative, under various reasons, a claim once entered may need to be unbundled into separate claims, as such the repricing engine, can unbundle the claim into separate claims, separate the claim codes accordingly and reprice the unbundled claims.

A second completed claim 310, illustrated in Figures 25a and 25b, is similar to completed claim 70 except it includes a Principal Procedure code '72' in code box 312, which designates a Normal Delivery. When repricing the second completed claim 310, the method, illustrated in Figure 22, determining that the Case Rate section applies, step 256, would determine the type of service 260. Next in step 262, the repricing engine would reprice the entire claim under the Normal Delivery Calculations defined in the Rate Sheet 200, and reprice the claim to \$2,300.00, illustrated in Figure 26 in Repricing window 320.

The contracts platform permits virtually all contracts to be interactive, meaning that the information is shared and used between the contracts and between the other platforms and engines. This allows the platforms to be changed, customized or new platforms may be added without damaging the integrity of the shared or stored information. As such as the industry or Insurer defines or re-defines the calculation categories or sections, the platforms may be changed or altered accordingly without damaging or effecting the information.

I. Additional Embodiments of the Present Invention

As mentioned above, the platforms may be designed to accept claims over various communication mediums. If utilized by third party administrators or by employers the ability to maintain a database to accept and reprice claims may be difficult, time consuming and expensive. As such the need exists to provide a single data center

maintaining and managing numerous networks. Referring to Figure 27, a single data center 330, is shown with a plurality of networks stored thereon, network A 332 corresponding to Insurer A; network B 332b corresponding to employer B; network C 332c corresponding to PPO C;...; network N 332n corresponding to Insurer n. Each network contains a plurality of rate sheets privy to the owner of the network, such as a PPO, Insurer, employer, or third party administrator. Various providers would submit reimbursement claims to the data center 330 over various wireline 334 and wireless 335 communication mediums. The data center would determine which network the claim is associated to and then reprice the claim and graphically display, transmit or electronically send to the submitter a reimbursement worksheet, such as the graphically displayed reimbursement window 300, Figure 24.

The data center is also accessible by the network's administrators, through various wireline 338 or wireless 339 communication mediums. The network's administrators would access their networks, and receive the submitted reimbursement claims along with corresponding reimbursement worksheet, so that payments to the submitter may be made. Other outside networks 342, such as Network XX, may be maintained and managed outside of the data center by the outside network's administrators. However, through various links the data center may be provided with access to the outside network 342. This would permit a provider 334 to submit a claim, to be reimbursed against the outside network 342. The data center receiving the claim would access the outside network 342 and reprice the claim against the rate sheets contained thereon. In this instance any proprietary information in relation to the rate sheets is maintained by the administrator of Network XX.

Moreover, the data center may be accessible to patients 340, through various mediums. Patients with submitted claims may be able to track the repayment or the repricing of claims submitted on their behalf. The data center may further be capable of maintaining cost histories of providers and PPOs. Insurers attempting to maintain, negotiate and create new networks of PPOs may be able to access these histories to determine possible risk allocation levels and to locate specific PPOs that meet their qualifications.

From the foregoing and as mentioned above, it will be observed that numerous variations and modifications may be effected without departing from the spirit and scope of the novel concept of the invention. It is to be understood that no limitation with respect to the specific methods and apparatus illustrated herein is intended or should be inferred. It is, of course, intended to cover by the appended claims all such modifications as fall within the scope of the claims.

We claim:

1. A method of repricing a reimbursement claim under at least one contract comprising:

5 converting each contract into a plurality of terms and a contract identifier code, each term, of the plurality of terms, containing qualification codes, calculation codes and at least two priority notes, and arranging the plurality of terms, of said contract, into a sequential series of terms;

converting the reimbursement claim into a series of claim lines, each claim line containing a claim code, a unit number and a corresponding charge;

10 sequentially comparing each claim code, of the series of claim lines, against each qualification code, of the plurality of terms and when a claim code, of a claim line, is substantially equal to a qualification code, of a term, identifying said term as a matching term associated to said claim line,

15 determining any priority conditions associated to all of the matching terms, and eliminating any matching terms that are excluded by said priority conditions; and

determining a reimbursement amount for the claim by processing the calculation codes of the non-eliminated matching terms.

20 2. The method of claim 1 wherein the priority conditions include:

categorizing the terms, of the sequential series of terms, into pre-defined sections, wherein the pre-defined sections have a hierarchy that lists a pre-defined section having priority over another pre-defined section prior to said other pre-defined section.

25 3. The method of claim 2 wherein the priority conditions further include:

arranging the terms, within each pre-defined section, by a reverse hierarchy, which sequential lists a term, having priority over another term, subsequent to said other term.

4. The method of claim 3 wherein the step of sequentially comparing further includes:

when a claim code, of a claim line, is substantially equal to a qualification code of a term, identifying the pre-defined section in which the term is categorized under as a governing pre-defined section for said claim line;

sequentially comparing the claim code of said claim line, only against the qualification codes, of each term categorized under said governing pre-defined section; and

when the claim code of said claim line is substantially equal to a qualification code, of a term categorized under said governing pre-defined section, identifying said term as a matching term associated to said claim line.

5. The method of claim 4 wherein the step of determining the reimbursement amount includes:

determining a reimbursement charge for each claim line associated to a non-eliminated matching term; and

adding the reimbursement charges for said claim lines, whereby the reimbursement amount for the claim is the addition of the reimbursement charges.

6. The method of claim 5 wherein when a priority note, of a non-eliminated matching term, indicates that the calculation codes, of said non-eliminated matching term, apply to the entire claim, making the reimbursement amount for the claim equal to the reimbursement charge for the claim line associated to said non-eliminated matching term.

7. The method of claim 6 wherein when a term, indicates that the calculation codes, of said term, apply to the reimburse amount of the claim, the method further including:

determining the reimbursement amount of said claim; and

when the qualifications of said term are satisfied, re-calculating the reimbursement amount based upon the calculation codes of said term.

8. The method of claim 7 wherein the step of converting the claim further includes the step of associating the claim to a claim identifier code.

5 9. The method of claim 8 further including:
comparing the claim identifier code, against the contract identifier code, of each contract, and when the claim identifier code is substantially equal to a contract identifier code, of a contract, identifying said contract as a governing contract, wherein the repricing of said claim is repriced only against said governing contract.

10

10. The method of claim 9 wherein the step of repricing the claim against said governing contract further includes:

when at least two contracts are identified as governing contracts, repricing said claim against each governing contract creating a list of governing reimbursement amounts.

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11. The method of claim 10 further comprising:
determining a lowest governing reimbursement amount, of the list of governing reimbursement amounts, wherein the lowest governing reimbursement amount is the reimbursement amount of said claim.

20

12. A method of repricing at least one reimbursement claim, for medical services, under at least one contract comprising:

inputting into a platform, each contract, of the at least one contract, each contract containing a contract identifier code and a series of contractual terms, each contractual term being defined by qualification codes, calculation codes and at least one priority note;

25

inputting into a platform, each claim, of the at least one claim, each claim containing a second identifier code and a series of claim lines, wherein each claim line being defined by a claim code, a unit number and a corresponding charge;

30

requesting a platform to reprice a claim, of the at least one claim, by determining a reimbursement amount for said claim; and

requesting a platform to display the reimbursement amount for said repriced claim.

5

13. The method of claim 12 wherein the step of determining a reimbursement amount includes:

comparing each claim code, of the claim, against each qualification code, of each contractual term, of a contract;

10 when a qualification code, of a contractual term, is satisfied by a claim code, of a claim line, identifying said contractual term as a matching contractual term associated to said claim line, and creating a list of all matching contractual terms;

determining any priority conditions associated to the matching contractual terms, and eliminating any matching contractual terms, from said list of matching terms
15 that are excluded by said priority conditions; and

determining a reimbursement charge for each claim line associated to a non-eliminated matching term, and adding the reimbursement charges for said claim lines, wherein the reimbursement amount for the claim is the addition of said reimbursement charges.

20

14. The method of claim 13 wherein the priority conditions further includes:

categorizing the contractual terms, of each contract, into a set of sequentially listed pre-defined sections, wherein the pre-defined sections have a hierarchy that lists a pre-defined section, having priority over another pre-defined section, before
25 said other pre-defined section.

25

15. The method of claim 14 wherein the priority conditions further includes:

arranging the contractual terms, categorized in each pre-defined section, in a reverse hierarchy, wherein a contractual term having priority over another contractual term is listed subsequent said other contractual term.

30

16. The method of claim 14 wherein the step of comparing each claim code against each qualification code includes:

when the claim further contains a claim priority condition, comparing each claim code only against qualification codes, of contractual terms listed in pre-defined sections that satisfy the claim priority condition.

17. The method of claim 16 wherein the priority conditions include a claim priority condition which eliminates any matching contractual terms that is listed in a pre-defined section that is excluded by the claim priority condition.

18. The method of claim 17 wherein when one of the priority notes associated to a matching contractual term indicates that said matching contractual term reprises the entire claim, eliminating all other matching contractual terms.

19. The method of claim 18 wherein the reverse hierarchy is determined by the priority notes associated to each contractual term, categorized in a pre-defined section.

20. The method of claim 13 wherein the step of repricing further includes:
comparing the claim identifier code against the contract identifier code, of each contract, wherein when the claim identifier code is substantially equal to a contract identifier code, of a contract, identifying said contract as a governing contract; and
determining a reimbursement amount of the claim only against the governing contract.

21. The method of claim 20 wherein the step determining a reimbursement amount for the claim against the governing contract includes:

when at least two contracts are identified as governing contracts, repricing said claim against each governing contract creating a list of governing reimbursement amounts, wherein the reimbursement amount of said claim is the lowest governing reimbursement amount.

22. The method of claim 21 further including:
storing the reimbursement amount of a claim and storing said claim as a
repriced claim.

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23. The method of claim 22 wherein prior to determining the reimbursement
amount for a claim the method including:

comparing the claim identifier code, of said claim, against the claim
identifier codes, of all stored repriced claims;

10

when the claim identifier code, of said claim is substantially equal to the
claim identifier codes, of a stored repriced claim, creating a bundled claim having the
combined claim lines of the claim lines of said claim with the claim lines of said repriced
claim;

15

determining the reimbursement amount of the bundled claim, instead of
determining the reimbursement amount of said claim; and

rewriting the reimbursement amount of the stored repriced claim with the
reimbursement amount of the bundled claim and rewriting the stored claim with the
bundled claim.

20

24. An article of manufacture comprising:

a computer usable medium having computer readable program code
embodied therein for repricing a reimbursement claim against at least one contract, said
claim containing a claim identifier, a plurality of claim lines and a total charge, said
contract containing a contract identifier and a plurality of contractual terms, the computer
readable program code means in the article of manufacture comprising:

25

computer readable program code means for causing a computer to
generate a rate sheet which represents a contract, of the at least one
contract, the rate sheet containing one or more rate terms that
represent the contractual terms of said contract, and containing a
rate identifier code that represents the contract identifier of said
contract;

30

computer readable program code means for causing a computer to generate the claim, the claim having a claim identifier codes and a series of claim lines, each claim line including a claim code, a unit number and a code charge;

5 computer readable program code means for causing a computer to reprice the claim against a rate sheet, and to generate and assign a reimbursement amount to said repriced claim; and

10 computer readable program code means for causing a computer to graphically display the reimbursement amount of the repriced claim, and a difference between the total charge of the claim and the reimbursement amount of the repriced claim.

25. The article of manufacture of claim 24, wherein the computer readable program code means for causing a computer to generate a rate sheet further includes:

15 computer readable program code means for causing a computer to assign qualification codes, calculation codes and at least one priority note to each rate term, and to arrange said rate terms into a sequential series of terms.

20 26. The article of manufacture of claim 25, wherein the computer readable program code means for causing a computer to generate a rate sheet further includes:

computer readable program code means for causing a computer to graphically convey the rate sheet by displaying the sequential series of terms in an English language representation.

25 27. The article of manufacture of claim 26, wherein the computer readable program code means for causing a computer to generate a rate sheet further includes:

30 computer readable program code means to generate and display each rate term as a English language paragraph with a series of data entry panels interspersed in the paragraph, the data entry panels

prompting a user to define the calculation codes, qualification codes and priority codes for each rate term.

28. The article of manufacture of claim 27, wherein the computer readable program code means for repricing the claim against a rate sheet further includes:

computer readable program code means causing a computer to sequentially compare each claim code, included in the series of claim lines, against each qualification code, of each rate term; and

when a claim code, of a claim line, is substantially equal to a qualification code, of a rate term, the computer readable program code means causing a computer to identify said rate term as a matching rate term associated to said claim line;

computer readable program code means causing a computer to determine any priority conditions associated to the matching rate terms and to eliminate any matching rate terms that are excluded by said priority conditions defining a series of remaining matching rate terms; and

computer readable program code means causing a computer to compute the reimbursement amount from the calculation codes of the remaining matching rate terms.

29. The article of manufacture of claim 28, wherein the computer readable program code means for causing a computer to generate a rate sheet further includes:

computer readable program code means to categorize the rate terms, of the rate sheet, in pre-defined sections, the pre-defined sections have a hierarchy sequence that assigns priority conditions to the rate terms categorized therein.

30. The article of manufacture of claim 29, wherein the article of manufacture further includes:

computer readable program code means causing a computer to assign priority conditions to the priority codes of the rate terms categorized within one of the pre-defined sections, said priority conditions defining a priority sequence of said rate terms.

5

31. The article of manufacture of claim 30, wherein the computer readable program code means for causing a computer to sequentially compare each claim code further includes:

10 when a claim code, of a claim line, is substantially equal to a qualification code, of a rate term, the computer readable program code means causing a computer to identify the pre-defined section in which the rate term is categorized under as a governing pre-defined section for said claim line;

computer readable program code means causing a computer to sequentially compare the claim code of said claim line, against only the qualification codes, of each rate term categorized under said governing pre-defined section; and

15

when the claim code of said claim line is substantially equal to a qualification code, of a term categorized under said governing pre-defined section, the computer readable program code means causing a computer to identify said term as a matching term associated to said claim line.

20

32. The article of manufacture of claim 31, wherein the article of manufacture further includes:

computer readable program code means causing a computer to compare the claim identifier against the rate identifier code and to identify a rate sheet as a governing rate sheet which has a rate identifier code substantially equal to the claim identifier; and

25

computer readable program code means causing a computer to reprice the claim only against a governing rate sheet.

30

33. The article of manufacture of claim 32, wherein the article of manufacture further includes:

when at least two rate sheets are identified as governing rate sheets,
computer readable program code means causing a computer to
reprice the claim against each governing rate sheet and to create a
list of governing reimbursement amounts.

5

34. The article of manufacture of claim 33, wherein the article of manufacture
further includes:

10

computer readable program code means causing a computer to receive an
input from an user to direct the computer to assign either the
highest or lowest governing reimbursement amount, from the list
of governing reimbursement amounts, as the reimbursement
amount of the repriced claim.

15

35. The article of manufacture of claim 34, wherein the article of manufacture
further includes:

20

computer readable program code means for causing a computer to store in
a repriced claim storage location a repriced claim along with the
reimbursement amount of said repriced claim, said repriced claim
includes the claim identifier code and claim lines associated to said
repriced claim.

25

36. The article of manufacture of claim 35, wherein the article of manufacture
further includes:

computer readable program code means for causing a computer to
compare the claim identifier code, of a claim, against the claim
identifier code, of each repriced claim, stored in the repriced claim
storage location;

30

when the claim identifier code, of said claim, is substantially equal to the
claim identifier code, of a repriced claim, the computer readable
program code means causing a computer to combine the claim

lines of said claim with the claim lines of said repriced claim to
create a bundled claim; and

computer readable program code means for causing a computer to reprice
the bundled claim and rewrite said repriced claim with the repriced
bundled claim.

37. The article of manufacture of claim 36, wherein the article of manufacture
further includes:

computer readable program code means causing a computer to store in a
rate sheet storage location the calculation codes, qualification
codes and priority codes of a rate sheet.

38. The article of manufacture of claim 37, wherein the article of manufacture
further includes:

computer readable program code means causing a computer to store in a
claim storage location the claim lines of a claim.

39. The article of manufacture of claim 38, wherein the article of manufacture
further includes:

computer readable program code means causing a computer to store in an
identifier storage location a plurality of identifier codes
substantially equal to the rate identifier codes, of each rate sheet,
and the claim identifier codes, of each claim; and

computer readable program code means causing a computer to logically
link each claim having a claim identifier code and each rate sheet
having a rate identifier code that are substantially equal to a single
identifier code, of the plurality of identifier codes; and

computer readable program code means causing a computer to receive
inputs from a user, said inputs to cause the computer to access the
identifier storage location and to change an identifier code, of the
plurality of identifier codes, whereby each claim and each rate

sheet logically linked to said identifier code is automatically changed.

40. A method for repricing a reimbursement claim against under at least one contract, (1) each claim containing at least one claim line, each claim line being defined by claim codes, a unit number and a corresponding charge, and (2) each contract containing at least one contractual term, each contractual term being defined by qualification codes, calculation codes, the method for repricing comprising:

comparing each claim code, of the claim, against each qualification code, of each contractual term, of a contract;

when a qualification code, of a contractual term, is satisfied by a claim code, of a claim line, identifying said contractual term as a matching contractual term associated to said claim line, and creating a list of all matching contractual terms;

determining any priority conditions associated to the matching contractual terms, and eliminating any matching contractual terms, from said list of matching terms that are excluded by said priority conditions; and

determining a reimbursement charge for each claim line associated to a non-eliminated matching term, and adding the reimbursement charges for said claim lines, wherein the reimbursement amount for the claim is the addition of said reimbursement charges.

41. The method of claim 40 further comprising:

storing each contract on a network contract storage location, the network storage location containing a plurality of contract sets, each contract set associated to a set identifier, each contract further including a contract identifier and a set identifier, wherein each contract containing a set identifier substantially equal to a set identifier of a contract set, is stored within said contract set;

identifying each claim with a set identifier and a claim identifier;

comparing the set identifier of a claim against the set identifier, of each contract set, when the set identifier of a claim is substantially equal to the set identifier of a contract set, identifying said contract set as a governing contract set;

comparing the claim identifier of said claim against the contract identifiers of each contract, stored within said governing contract set, and when the claim identifier of said claim is substantially equal to the contract identifier of a contract, stored within said governing contract set, identifying said contract as a governing contract; and

5 determining the reimbursement amount of said claim only against said governing contract.

42. The method of claim 41 wherein the priority conditions further includes:
categorizing the contractual terms, of each contract, into a set of
10 sequentially listed pre-defined sections, wherein the pre-defined sections have a hierarchy that lists a pre-defined section, having priority over other pre-defined sections, before said other pre-defined sections.

43. The method of claim 42 wherein the priority conditions further includes:
15 arranging the contractual terms, categorized in each pre-defined section, in a reverse hierarchy, wherein a contractual term having priority over other contractual terms is listed subsequent said other contractual terms.

44. The article of manufacture of claim 43, wherein the computer readable
20 program code means for causing a computer to sequentially compare each claim code further includes:

when a claim code, of a claim line, is substantially equal to a qualification code, of a contractual term, the computer readable program code means causing a computer to identify the pre-defined section in which the contractual term is categorized
25 under as a governing pre-defined section for said claim line;

computer readable program code means causing a computer to sequentially compare the claim code of said claim line, against only the qualification codes, of each contractual term categorized under said governing pre-defined section; and

when the claim code of said claim line is substantially equal to a
30 qualification code, of a term categorized under said governing pre-defined section, the

computer readable program code means causing a computer to identify said contractual term as a matching contractual term associated to said claim line.

5 45. The method of claim 44 wherein the priority conditions include a claim priority condition which eliminates any matching contractual terms that is listed in a pre-defined section that is excluded by the claim priority condition.

10 46. The method of claim 45 wherein when one of the priority notes associated to a matching contractual term indicates that said matching contractual term reprices the entire claim, eliminating all other matching contractual terms.

15 47. The method of claim 46 wherein the reverse hierarchy is determined by the priority notes associated to each contractual term, categorized in a pre-defined section.

20 48. The method of claim 47 wherein the step of repricing further includes:
 comparing the claim identifier code against the contract identifier code, of each contract, wherein when the claim identifier code is substantially equal to a contract identifier code, of a contract, identifying said contract as a governing contract; and
 determining a reimbursement amount of the claim only against the governing contract.

25 49. The method of claim 48 wherein the step determining a reimbursement amount for the claim against the governing contract includes:
 when at least two contracts are identified as governing contracts, repricing said claim against each governing contract creating a list of governing reimbursement amounts, wherein the reimbursement amount of said claim is the lowest governing reimbursement amount.

30 50. The method of claim 49 further including:

storing the reimbursement amount of a claim and storing said claim as a repriced claim.

51. The method of claim 50 wherein prior to determining the reimbursement amount for a claim the method including:

comparing the claim identifier code, of said claim, against the claim identifier codes, of all stored repriced claims;

when the claim identifier code, of said claim is substantially equal to the claim identifier codes, of a stored repriced claim, combining the claim lines of said claim with the claim line of said repriced claim creating a bundled claim;

determining the reimbursement amount of the bundled claim, instead of determining the reimbursement amount of said claim; and

rewriting the reimbursement amount of the stored repriced claim with the reimbursement amount of the bundled claim and rewriting the stored claim with the bundled claim.

52. The method of claim 40 further comprising:

tracking the priority conditions associated to the non-eliminated matching terms; and

displaying said priority conditions along with the reimbursement charge of the claim lines associated with said non-eliminated matching terms.

53. An article of manufacture comprising:

a computer usable medium having computer readable program code embodied therein for configuring a contract, containing contractual terms, for repricing a reimbursement claim, the computer readable program code means in the article of manufacture comprising:

computer readable program code means for causing a computer to generate a rate sheet representing the contractual terms of said contract, the rate sheet containing identifier codes, and one or more rate terms;

computer readable program code means for causing a computer to arrange
the rate terms in a sequential series of terms; and
computer readable program code means for graphically conveying the rate
sheet by displaying the sequential series of terms in an English
language representation.

5

54. The article of manufacture of claim 53, wherein the article of manufacture further includes:

computer readable program code means to generate and display each rate
term as a English language paragraph with a series of data entry
panels interspersed in the paragraph, the data entry panels
prompting a user to define calculation codes, qualification codes
and priority codes for each rate term.

10

55. The article of manufacture of claim 54, wherein the article of manufacture further includes:

computer readable program code means to categorize the rate terms, of the
rate sheet, in pre-defined sections, wherein the pre-defined sections
have a pre-defined hierarchy sequence that assigns a priority to the
rate terms categorized therein when repricing a claim.

15

20

56. The article of manufacture of claim 55, wherein the English language paragraph describes the qualification and calculation of the rate term when repricing a medical reimbursement claim.

25

57. The article of manufacture of claim 56, wherein the priority codes define a priority sequence to the rate terms within a pre-defined section, of said pre-defined sections.

30

58. The article of manufacture of claim 57, wherein the article of manufacture further includes:

computer readable program code means to permit a user to edit the calculation codes, qualification codes and priority codes of a rate term of the rate sheet.

5

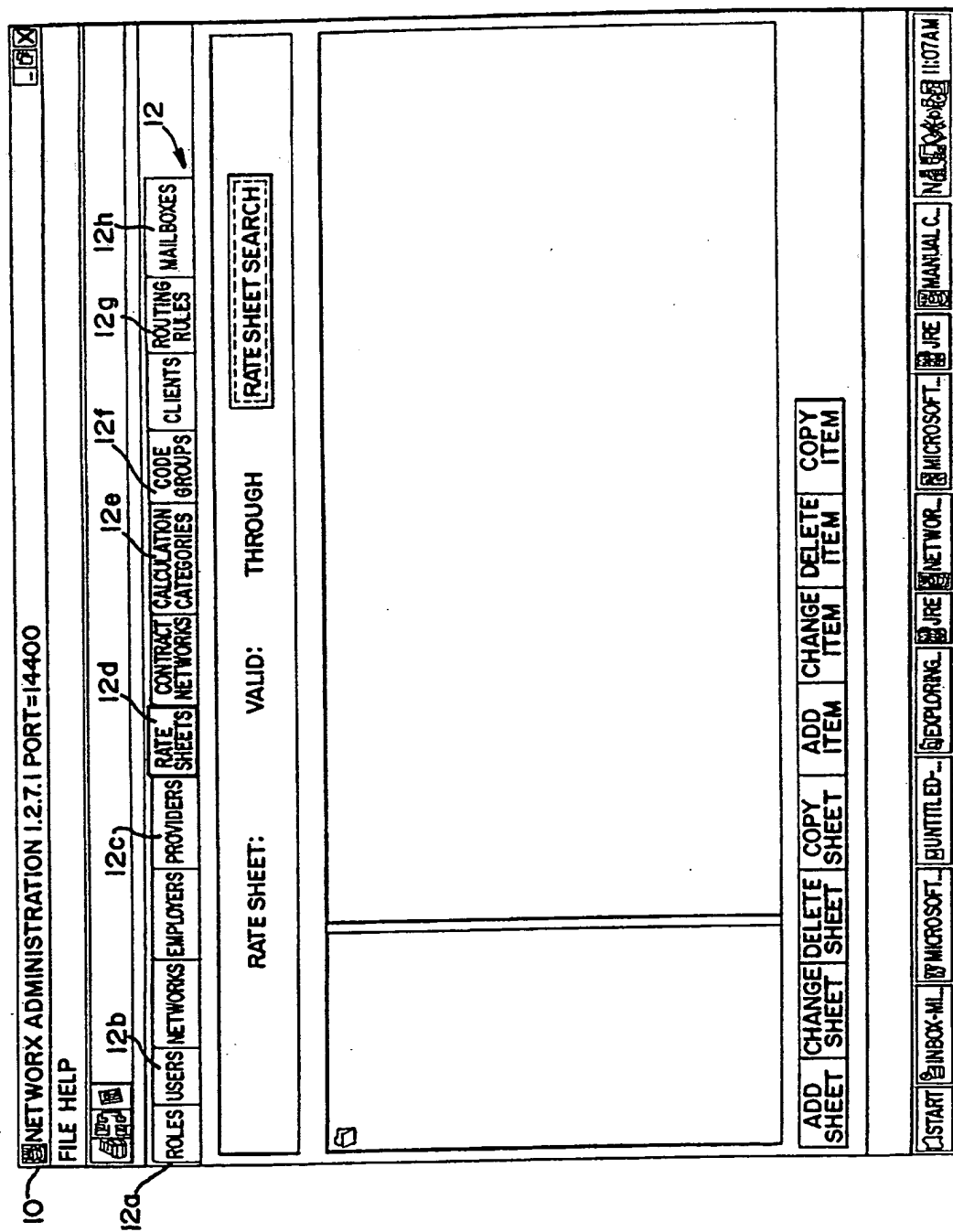
59. The article of manufacture of claim 58, wherein the article of manufacture further includes:

computer readable program code means to store a rate sheet, in a data center containing a plurality of networks, each network containing a plurality of rate sheets, similarly configured; and

10

when the identifier codes of a rate sheet identifier a specific network, of the plurality of networks, the computer readable program code means stores said rate sheet in the specific network.

15



NETWORKX ADMINISTRATION 1.2.7.1 PORT=14400											
FILE HELP											
12c)											
ROLES	USERS	NETWORKS	EMPLOYERS	PROVIDERS	RATE SHEETS	CONTRACT NETWORKS	CALCULATION CATEGORIES	CODE GROUPS	CLIENTS	ROUTING RULES	MAIL BOXES

SEARCH

PROVIDER NAME:
 PARTIAL TAX ID:
 NETWORK:

PROVIDERS

PROVIDER ALIASES

ALIASES

ADDRESS

NETWORKS

START	INBOX-MICROS...	MICROSOFT WOR...	UNTTLED-MES...	EXPLORING-REP...	JRE	NETWORK A...	MICROSOFT OFFC...	NA BOOK 6/8/97	11:02 AM
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FIG. 3.10

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12d												
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32a	32b	32c	32d	32e	32f	32g	32h					
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FIG. 4

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NETWORKX ADMINISTRATION 1.2.7.1 PORT=14400

FILE HELP

12c

ROLES	USERS	NETWORKS	EMPLOYERS	PROVIDERS	RATE SHEETS	CONTRACT NETWORKS	CALCULATION CATEGORIES	CODE GROUPS	CLIENTS	ROUTING RULES	MAILBOXES
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CATEGORIES

CATEGORY DESCRIPTION
ALL CALCULATIONS
AMBULATORY SURGERY
BOARDER BABY CALCS
CASE RATES
COST CALCULATIONS
DISCOUNT CALCULATIONS
DRGS
MAXIMUM AMOUNTS
NON COVERED SERVICES
PER DIEMS
PERCENTAGES
REASONABLE & CUSTOMARY
SCHEDULES
STOP LOSS
UNIT CALCULATIONS

CALCULATIONS

CALCULATION DESCRIPTION
2 LEVEL PER DIEM
2 LEVEL PER DIEM LTD BY PCT OF CHG
3 LV PER DIEM
4 LEVEL PER DIEM
PER DIEM
PER DIEM EXCESS DAYS

ADD

CHANGE

DELETE

START

INBOX MICROSOFT

EXPLORE REP...

UNTITLED MES...

Microsoft Word

JRE

NETWORK A...

Microsoft Office...

NA

11:03 AM

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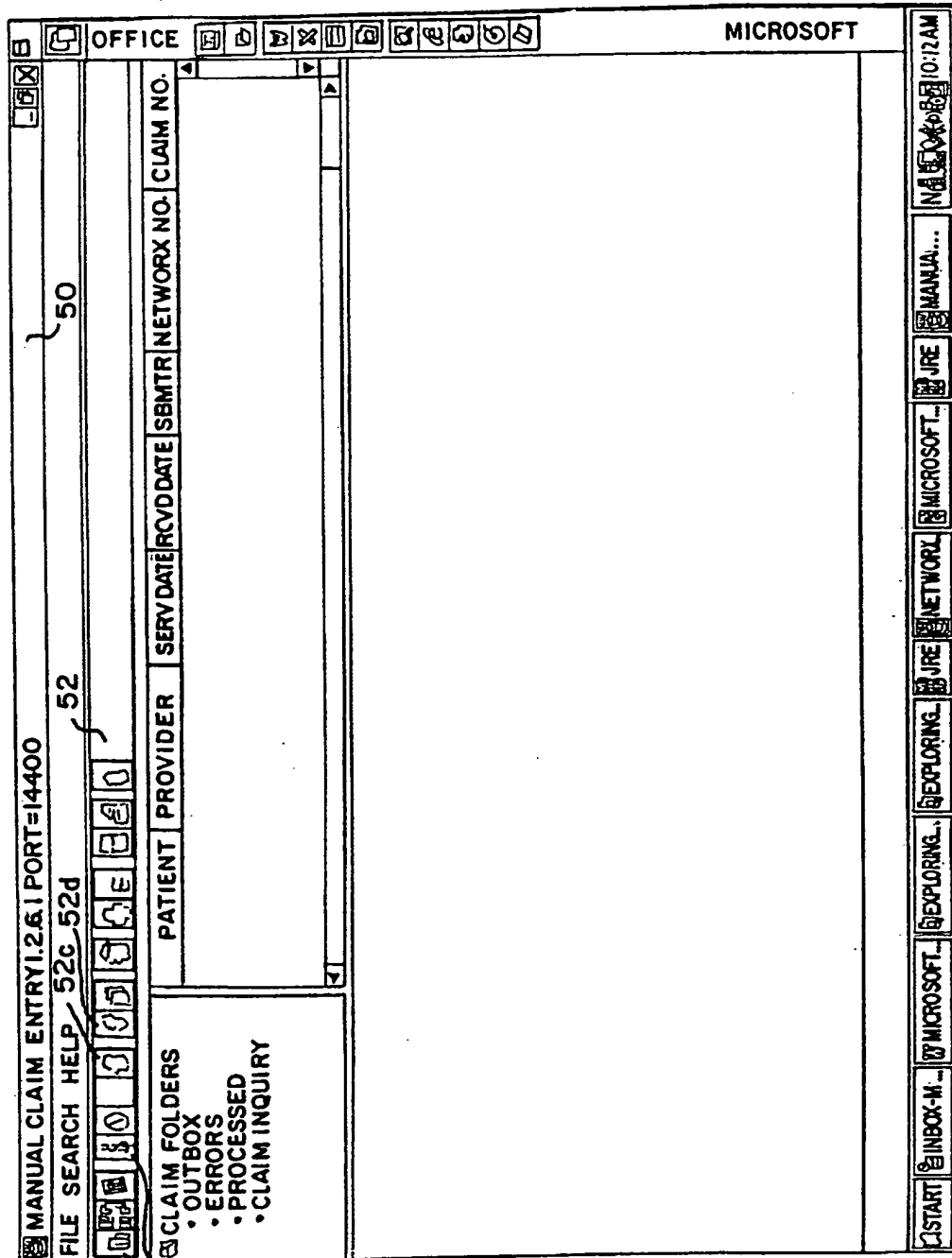


FIG. 5

52a

52b

FIG. 6a

6/35

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FIG. 6b

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MANUAL CLAIM ENTRY 1.2.7.1 PORT=14400									
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FIG. 6c

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<div style="display: flex; justify-content: space-between;"> <div> <input checked="" type="checkbox"/> CLAIM FOLDERS <input checked="" type="checkbox"/> OUTBOX <input type="checkbox"/> ERRORS <input type="checkbox"/> PROCESSED <input type="checkbox"/> CLAIM INQUIRY </div> <div> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>PATIENT</th> <th>PROVIDER</th> <th>SERV DATE</th> <th>RCVD DATE</th> <th>SBMTR</th> <th>NETWORK NO.</th> <th>CLAIM NO.</th> </tr> <tr> <td colspan="7" style="height: 40px;"></td> </tr> </table> </div> </div>										PATIENT	PROVIDER	SERV DATE	RCVD DATE	SBMTR	NETWORK NO.	CLAIM NO.																																									
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<div style="display: flex; justify-content: space-between;"> <div> <div style="border: 1px solid black; width: 150px; height: 20px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> <div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATED ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)</div> <div>22. MEDICAID ORIGINAL RESUBMISSION CODE REF. NO.</div> </div> <div style="display: flex; justify-content: space-between;"> <div>1. <div style="border: 1px solid black; width: 60px; height: 20px;"></div></div> <div>3. <div style="border: 1px solid black; width: 60px; height: 20px;"></div></div> </div> <div style="display: flex; justify-content: space-between;"> <div>2. <div style="border: 1px solid black; width: 60px; height: 20px;"></div></div> <div>4. <div style="border: 1px solid black; width: 60px; height: 20px;"></div></div> </div> </div> <div>23. PRIOR AUTHORIZED NUMBER <div style="border: 1px solid black; width: 150px; height: 20px;"></div></div> </div>																																																									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">24. A</th> <th>B</th> <th>C</th> <th>D</th> <th>E</th> <th>F</th> <th>G</th> <th>H</th> <th>I</th> <th>J</th> <th>K</th> </tr> <tr> <td colspan="2">DATES OF SERVICE</td> <td colspan="2">CPT/ MODIFIER</td> <td colspan="2">DIAGNOSI</td> <td colspan="2">DAYS</td> <td colspan="2">EMG</td> <td colspan="2">RESERVED</td> </tr> <tr> <td>FROM</td> <td>TO</td> <td>POSTOS</td> <td>HCPCS</td> <td>CODE</td> <td>CHARGES</td> <td>UNITS</td> <td>EPSDT</td> <td>COB</td> <td>USE</td> <td>HRS.</td> <td>MNS. COST</td> </tr> <tr> <td colspan="12" style="height: 100px;"></td> </tr> </table>										24. A		B	C	D	E	F	G	H	I	J	K	DATES OF SERVICE		CPT/ MODIFIER		DIAGNOSI		DAYS		EMG		RESERVED		FROM	TO	POSTOS	HCPCS	CODE	CHARGES	UNITS	EPSDT	COB	USE	HRS.	MNS. COST												
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<div style="display: flex; justify-content: space-between;"> <div> SIGNED <div style="border: 1px solid black; width: 80px; height: 20px;"></div> DATE <div style="border: 1px solid black; width: 40px; height: 20px;"></div> </div> <div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> </div> <div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> </div> </div>																																																									
<div style="display: flex; justify-content: space-between;"> <div>PIN# <div style="border: 1px solid black; width: 50px; height: 20px;"></div></div> <div>GRP# <div style="border: 1px solid black; width: 50px; height: 20px;"></div></div> </div>																																																									
<div style="display: flex; justify-content: space-between;"> <div>START</div> <div>INBOX-ML</div> <div>MICROSOFT</div> <div>UNTITLED-</div> <div>EXPLORING</div> <div>RE</div> <div>NETWORK</div> <div>MICROSOFT</div> <div>RE</div> <div>MANUAL</div> <div>NEW</div> <div>FILE:OSAM</div> </div>																																																									

FIG. 7

9/35

MANUAL CLAIM ENTRY 1.2.6.1 PORT=14400

FILE SEARCH HELP

OUTBOX
ERRORS
PROCESSED
ALL
COMPLETED CLAIMS
COST EXCESS DAYS MANUAL

PATIENT	PROVIDER	SERV DATE	RCVD DATE	SBMTR	NETWORK NO.	CLAIM NO.
SUBHALLA R D S P C T 2 EY	ST. MICHAEL HEALTH CARE CENTER	200-01-00	200-03-00			
SUBHALLA R D S P C T 2 EY	ST. MICHAEL HEALTH CARE CENTER	200-01-00	200-03-00			
SUBHALLA R D S P C T 2 EY	ST. MICHAEL HEALTH CARE CENTER	200-01-00	200-03-00			
VARIABLE PER DEM EY	HARDY MEDICAL CENTER	200-01-00	200-03-00	ORVALC		

RECEIVED 02/29/2000 CLAIM NO. []

MEDICAL CENTER 1305 CROWLEY LA 70526

3. PATIENT CONTROL NUMBER 4. TYPE OF BILL

6. STATEMENT TAX NO. 7. COVD 8. N-CD 9. G-ID 10. L-R 11. D-II

12. PATIENT NAME LAST FIRST MI STREET CITY STATE ZIP CODE

ADMISSION 14. BIRTH DATE 15. SEX 16. MS 17. DATE 18. HR 19. TYPE 20. SRC 21. H-1 22. STAT 23. MEDICAL RECORD NO 24. 25. 26. 27. 28. 29. 30. 31.

32. OCCURRENCE CODE DATE 33. OCCURRENCE CODE DATE 34. OCCURRENCE CODE DATE 35. OCCURRENCE CODE DATE 36. OCCURRENCE CODE DATE 37. OCCURRENCE SPAN FROM THROUGH

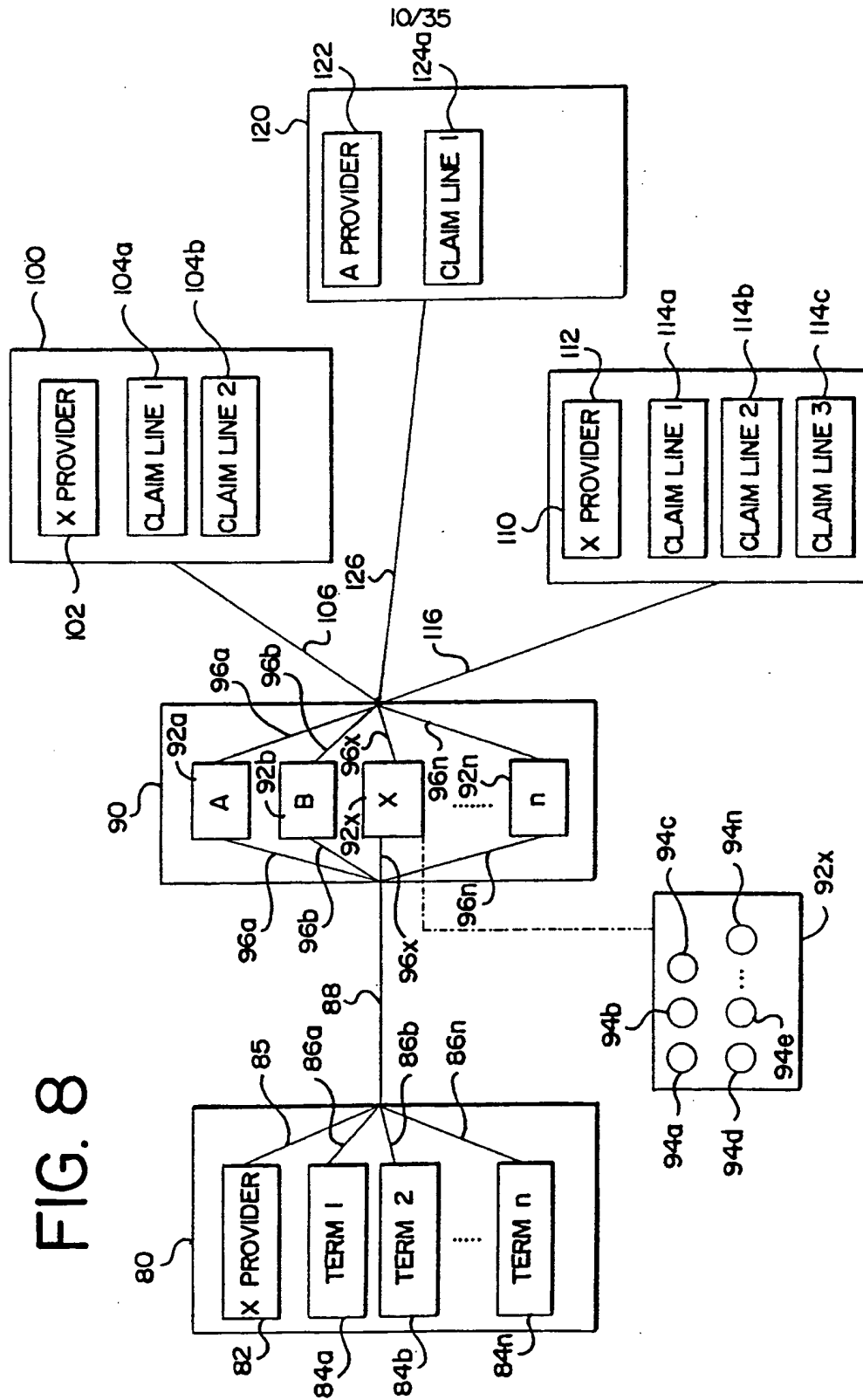
38. LAST FIRST MI 39. VALUE CODES CODE AMOUNT 40. VALUE CODES CODE AMOUNT 41. VALUE CODES CODE AMOUNT

42. REV CODE 43. DESCRIPTION 44. HCPCS RATES 45. SERV. DATE 46. SERV. UNITS 47. TOTAL CHARGES 48. NON-COVERED 49. COST

120	ROOM-BOARD/SIM		4	\$4,000.00		
350	CORONARY CARE OR C		1	\$6,000.00		
250	PHARMACY			\$10,000.00		
001	TOTAL CHARGES			\$20,000.00		

4:04 PM

FIG. 8



11/35

FIG.9

140

PROVIDER CONTRACT

MEDICAL CENTER 11-9999999
EFFECTIVE 04/01/1999

HOSPITAL AGREES TO PROVIDER COVERED HOSPITAL
SERVICES ON THE PAYMENT TERMS SET FORTH BELOW.

HOSPITAL AGGREGES TO PROVIDE ALL COVERED INPATIENT
AND OUTPATIENT SERVICES ACCORDING TO THE FOLLOWING
ALL INCLUSIVE PER DIEM AND DISCOUNT ARRANGEMENTS:

\$750.00 MEDICAL PER DIEM
\$950.00 SURGICAL PER DIEM

NORMAL DELIVERY (MOTHER & BABY)
\$1,400.00 1-2 DAY STAY CASE RATE
\$450.00 EACH ADDITIONAL DAY

CESAREAN SECTION (MOTHER & BABY)
\$2,800.00 1-2 DAY STAY CASE RATE
\$500.00 EACH ADDITIONAL DAY

ALL OTHER COVERED IMPATIENT SERVICES: 15% DISCOUNT
FROM BILLED CHARGES
OUTPATIENT SERVICES: 15% DISCOUNT FROM BILLED CHARGES

STOP LOSS: FOR ANY CASE IN WHICH CHARGES EXCEED
\$20,000.00, HOSPITAL WILL BE PAID 85% OF BILLED CHARGES.

12/35

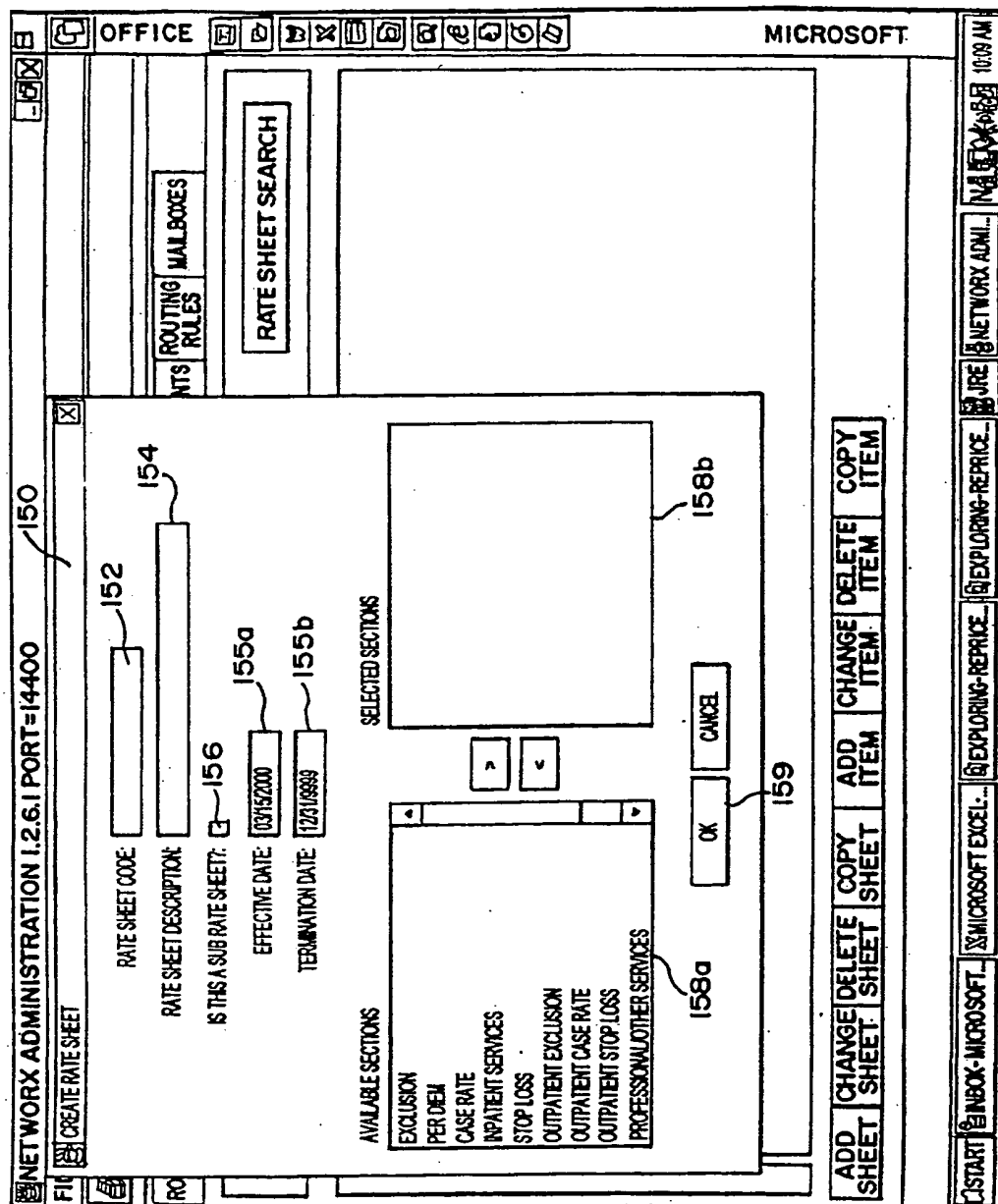


FIG. 10a

13/35

FIG. 10b

NETWORK ADMINISTRATION 1.2.7.1 PORT=14400

FILE EDIT VIEW TOOLBOX HELP

ROUTING RULES MAILBOXES

RATE SHEET SEARCH

RATE SHEET CODE:

RATE SHEET DESCRIPTION:

IS THIS A SUB RATE SHEET? ☐

EFFECTIVE DATE:

TERMINATION DATE:

AVAILABLE SECTIONS

- EXCLUSION
- INPATIENT SERVICES
- OUTPATIENT EXCLUSION
- OUTPATIENT CASE RATE
- OUTPATIENT STOP LOSS
- PROFESSIONAL/OTHER SERVICES
- OUTPATIENT PER DEM

SELECTED SECTIONS

- PER DEM
- CASE RATE
- OUTPATIENT SERVICES
- STOP LOSS

158b

OK CANCEL

ADD SHEET CHANGE SHEET DELETE SHEET COPY SHEET

ADD ITEM CHANGE ITEM DELETE ITEM COPY ITEM

START INBOX-ML MICROSOFT BUNTLED- EXPLORING JRE NETWORK MICROSOFT JRE MANUAL C. NETWORK 11:08 AM

14/35

FIG. 11

NETWORKX ADMINISTRATION 1.2.7.1 PORT=14400

FILE HELP

ROLES **USERS** **NETWORKS** **EMPLOYERS** **PROVIDERS** **RATE SHEETS** **CONTRACT NETWORKS** **CALCULATION CATEGORIES** **CODE GROUPS** **CLIENTS** **ROUTING RULES** **MAILBOXES** **162**

RATE SHEET: HMC **VALID: 04-01-1999 THROUGH 12-31-9999** **RATE SHEET SEARCH** **168**

HMC MEDICAL CENTER

1. PER DIEM

2. CASE RATE

3. OUTPATIENT SERVICES

4. STOP LOSS

FOOTNOTES

1-THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE SMALLEST AMOUNT.

2-THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LARGEST AMOUNT.

3-THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LAST TERM TO QUALIFY.

PLEASE NOTE: NO MORE TERMS WILL BE EXAMINED FOR THIS CLAIMLINE IF IT QUALIFIES UNDER THESE TERMS.

152e

ADD CHANGE DELETE COPY **ADD CHANGE DELETE COPY** **166**

SHEET SHEET SHEET SHEET **ITEM ITEM ITEM ITEM**

START INBOX-ML MICROSOFT- BUNTTLED- EXPLORING- FIRE NETWORK- MICROSOFT- FIRE MANUAL C- NA 11:07AM

160

164

15/35

FIG.12

RATE SHEET TERMS

DESCRIPTION: ☒ HEADING 172a 172b 172d

DESCRIPTION: 172c

EFFECTIVE DATES: 12/31/1999

QUALIFICATIONS: 174a

☐ CODE VALUES ☐ CODE GROUPING

CODE TYPES: 174

-SELECT CODE TYPE- 174c

CALCULATIONS: 170

☐ CALCULATIONS ☐ ACTIONS ☐ SUBRATE SHEETS

CALCULATION CATEGORIES: 176

☐ ALL CALCULATIONS

☐ ANOTHER TEST ADD CALC

☐ CASE RATES

☐ CASE RATES BS

☐ CASE RATES QUALCARE

☐ COST CALCULATIONS

☐ DISCOUNT CALCULATIONS

☐ DRGS

☐ MAXIMUM AMOUNTS

☐ MY TEST CALCULATION

☐ COMPLETE

OK CANCEL

178

176b

16/35

FIG. 12a

QUALIFICATIONS

☒ CODE VALUES ☐ CODE GROUPING

CODE TYPES: DRG CODE(S) ▼

VALUE RANGE: 103 TO 109

175a 175b

FIG. 12b

QUALIFICATIONS

☐ CODE VALUES ☒ CODE GROUPING

CODE TYPES: -SELECT CODE TYPE-- ▼

CODE GROUPS -SELECT CODE GROUP-- ▼

AICD (ACID?)
ALC SCHEDULE CODE VALUES
ALCOHOL & DRUG
ALCOHOL & DRUG DAY PROGRAM?
AMBULATORY SURGERY
ASFGD
BLOOD FACTOR 8 AND 9
C-SECTION

177

17/35

FIG. 13a

RATE SHEET TERMS

DESCRIPTION ☐ **HEADING** 182a 182c

DESCRIPTION 182b

EFFECTIVE DATES: 04/01/1997 05/31/1999

QUALIFICATIONS 184

☐ **CODE VALUES** 184a ☐ **CODE GROUPING** 184c

CODE TYPES: REVENUE CODE(S)

CODE GROUPS: PER DIEM/MEDICAL 184b

CALCULATIONS 186

☒ **CALCULATIONS** ☐ **ACTIONS** ☐ **SUBRATE SHEETS**

☐ **CALCULATION CATEGORIES**

☐ ALL CALCULATIONS

☐ CASE RATES

☐ COST CALCULATIONS

☐ DISCOUNT CALCULATIONS

☐ DRGS

☐ MAXIMUM AMOUNTS

☐ NON-COVERED SERVICES

☐ PER DIEMS

☐ 2 LEVEL PER DIEM

☐ **COMPLETE**

PER DIEM 188

PRICING IS 188a \$350.00 PER DIEM

THIS CALCULATION WILL BE USED TO REPRICE THE **CURRENT LINE** 189a WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM. THIS PRICE WILL BE USED IF IT IS THE **LAST TERM TO QUALIFY** 189b

OK **CANCEL** 190

FIG. 13b

RATE SHEET TERMS

198

194

DESCRIPTION

☐ HEALING

☐ SURGICAL

EFFECTIVE DATES:

04/07/1997 12/31/9999

QUALIFICATIONS

☐ CODE VALUES ☒ CODE GROUPING 192a

CODE TYPES: REVENUE CODE(S) 192b

CODE GROUPS: PER DENT/MEDICAL 192b

PER DEM

PRICING IS \$950.00 PER DEM

THIS CALCULATION WILL BE USED TO REPRICE THE **CURRENT LINE** WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM. THIS PRICE WILL BE USED IF IT IS THE **LAST TERM TO QUALIFY**.

☐ ALL CALCULATIONS

☐ 2 LEVEL PER DEM

☐ 2 LEVEL PER DEM, LTD BY PCT OF CHG

☐ 2 LEVEL SERVICES

☐ 2 LV CASE + EXCESS PCT, LTD BY CHG

☐ 2 LV CASE + PD, LTD BY CHG

☐ 2 LV CASE, LTD BY CHG

☐ 3 LV CASE + PD, LTD BY CHG

☐ 3 LV CASE, LTD BY CHG

☐ 3 LV PER DEM

CALCULATIONS ☐ ACTIONS ☐ SUBRATE SHEETS

☒ COMPLETE

১৫৯

NETWORK ADMINISTRATION I.2.7.1 PORT=1400									
FILE HELP									
ROLES	USERS	NETWORKS	EMPLOYERS	PROVIDERS	RATE SHEETS	CONTRACT NETWORKS	CALCULATION CATEGORIES	CODE GROUPS	CLIENTS MAILBOXES
					RATE SHEET SEARCH VALID: 04-01-1999 THROUGH 12-31-9999 RATE SHEET: HMC				
HMC - HARDY MEDICAL CENTER <input checked="" type="checkbox"/> PER DIEM <input type="checkbox"/> CASE RATE <input type="checkbox"/> OUTPATIENT SERVICES <input type="checkbox"/> STOP LOSS <input type="checkbox"/> FOOTNOTES					1. PER DIEM 1.1 MEDICAL CODE GROUP - PER DIEM - MEDICAL PRICING IS \$750.00 PER DIEM -2,6 1.2 SURGICAL CODE GROUP - PER DIEM - SURGICAL PRICING IS \$950.00 PER DIEM -2,6 2. CASE RATE 3. OUTPATIENT SERVICES 4. STOP LOSS FOOTNOTES 1-THE CALCULATION WILL BE USED TO REPRICE THE ENTIRE CLAIM. 2-THE CALCULATION WILL BE USED TO REPRICE THE CURRENT LINE. 3-THE CALCULATION WILL BE USED TO REPRICE THE WATCHING LINE AS A GROUP. 4-WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE SMALLEST AMOUNT. 5-WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LARGEST AMOUNT. 6-WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LAST TERM TO QUALIFY. 7-PLEASE NOTE: NO MORE TERMS WILL BE EXAMINED FOR THIS CLAIMLINE IF IT QUALIFIES UNDER THESE TERMS.				
ADD CHANGE DELETE SHEET					ADD CHANGE DELETE COPY SHEET				
SHEET ITEM					SHEET ITEM				

DATE: 04-01-1999
 TIME: 11:18 AM

20/35

FIG. 14

RATE SHEET TERMS

☐ HEADING

DESCRIPTION:

EFFECTIVE DATES:

QUALIFICATIONS

☐ CODE VALUES ☒ CODE GROUPING

CODE TYPES:

CODE GROUPS:

197b

CALCULATIONS ☒ CALCULATIONS ☐ ACTIONS ☐ SUBRATE SHEETS

☒ ALL CALCULATIONS

- ☐ 2 LEVEL PER DIEM
- ☐ 2 LEVEL PER DIEM, LTD BY PCT OF CHG
- ☐ 2 LEVEL SERVICES
- ☐ 2 LV CASE + EXCESS PCT, LTD BY CHG
- ☐ 2 LV CASE + PD, LTD BY CHG
- ☐ 2 LV CASE, LTD BY CHG
- ☐ 3 LV CASE + PD, LTD BY CHG
- ☐ 3 LV CASE, LTD BY CHG
- ☐ 3 LV PER DIEM

☐ COMPLETE

197c

CASE RATE PLUS PER DIEM, LIMITED BY CHARGE, 197c

PRICING IS A CASE RATE OF FOR UP TO DAYS AND PER DIEM FOR EACH ADDITIONAL DAY.

LIMIT THE ALLOWED TO THE **197d**

THIS CALCULATION WILL BE USED TO REPRICE THE WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM. THIS PRICE WILL BE USED IF IT IS THE **197d**

21/35

FIG.15

RATE SHEET TERMS

☐ **DESCRIPTION** ☐ **HEADING**

DESCRIPTION: C-SECTION (MOM & BABY)

EFFECTIVE DATES: 04/01/1997 12/31/9999

QUALIFICATIONS

☐ **CODE VALUES** ☒ **CODE GROUPING**

CODE TYPES: ICD-9 PROCEDURE CODE(S)

CODE GROUPS: C-SECTION

CALCULATIONS ☐ **CALCULATIONS** ☐ **ACTIONS** ☐ **SUBRATE SHEETS**

☒ **ALL CALCULATIONS**

- ☐ 2 LEVEL PER DEM
- ☐ 2 LEVEL PER DEM, LTD BY PCT OF CHG
- ☐ 2 LEVEL SERVICES
- ☐ 2 LV CASE + EXCESS PCT, LTD BY CHG
- ☐ 2 LV CASE + PD, LTD BY CHG
- ☐ 2 LV CASE, LTD BY CHG
- ☐ 3 LV CASE + PD, LTD BY CHG
- ☐ 3 LV CASE, LTD BY CHG
- ☐ 3 LV PER DEM

☐ **COMPLETE**

CASE RATE PLUS PER DEM, LIMITED BY CHARGE
 PRICING IS A CASE RATE OF \$2,800.00 FOR UP TO 12 DAYS AND \$500.00 PER DEM FOR EACH ADDITIONAL DAY.
 LIMIT THE ALLOWED TO THE COMBINED CHARGES.

THIS CALCULATION WILL BE USED TO REPRICE THE ENTIRE CLAIM WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LAST TERM TO QUALIFY.

FIG. 16

<div style="display: flex; justify-content: space-between;"> ⊗ RATE SHEET TERMS ⊗ </div>	
<p>DESCRIPTION</p> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;"> <input type="checkbox"/> HEADING </div> <p>DESCRIPTION: </p> <p>EFFECTIVE DATES: </p>	<div style="display: flex; justify-content: space-between;"> <div> <p>QUALIFICATIONS</p> <p>⊙ CODE VALUES ⊙ CODE GROUPING</p> <p>CODE TYPES: </p> </div> <div> <p>CALCULATIONS</p> <p>⊙ CALCULATIONS ⊙ ACTIONS ⊙ SUBRATE SHEETS</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>CALCULATION CATEGORIES</p> <p><input type="checkbox"/> ALL CALCULATIONS</p> <p><input type="checkbox"/> CASE RATES</p> <p><input type="checkbox"/> COST CALCULATIONS</p> <p><input type="checkbox"/> DISCOUNT CALCULATIONS</p> <p style="padding-left: 20px;"> <input type="checkbox"/> DISCOUNT PCT <input type="checkbox"/> DISCOUNT PCT W/ THRESHOLD <input type="checkbox"/> PROVIDER DISCOUNT PCT </p> <p><input type="checkbox"/> DRGS</p> <p><input type="checkbox"/> MAXIMUM AMOUNTS</p> <p><input type="checkbox"/> NON-COVERED SERVICES</p> <p><input type="checkbox"/> COMPLETE</p> </div> </div> </div>
<p>DISCOUNT PERCENT</p> <p>PRICING IS A DISCOUNT OF THE CHARGE.</p> <p>THIS CALCULATION WILL BE USED TO REPLACE THE WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE </p> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> OK CANCEL </div>	

23/35

FIG.17

RATE SHEET ITEMS

☐ HEADING
☐ ALL OTHER INPATIENT SERVICES
 EFFECTIVE DATES: 04/01/1997 12/31/9999

QUALIFICATIONS
☐ CODE VALUES ☐ CODE GROUPING
☐ ALL OTHER OUTPATIENT SERVICES

CALCULATIONS
☒ CALCULATIONS ☐ ACTIONS ☐ SUBRATE SHEETS
☒ CALCULATION CATEGORIES
☐ ALL CALCULATIONS
☐ CASE RATES
☐ COST CALCULATIONS
☒ DISCOUNT CALCULATIONS
☐ DISCOUNT PCT
☐ DISCOUNT PCT W/ THRESHOLD
☐ PROVIDER DISCOUNT PCT
☐ DRGS
☐ MAXIMUM AMOUNTS
☐ NON-COVERED SERVICES
☐ COMPLETE

DISCOUNT PERCENT
 PRICING IS AT 15% DISCOUNT OF THE CHARGE
 THIS CALCULATION WILL BE USED TO REPRICE THE ENTIRE CLAIM WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM. THIS PRICE WILL BE USED IF IT IS THE LAST TERM TO QUALIFY.

OK CANCEL

24/35

FIG.18

RATE SHEET TERMS

DESCRIPTION
☐ HEAVY
☒ STOP LOSS
 EFFECTIVE DATES: 04/01/1997 12/31/9999

QUALIFICATIONS
☒ CODE VALUES
☐ CODE GROUPING
 CODE TYPES: ALL REMAINING CODES

CALCULATIONS
☒ CALCULATIONS
☐ ACTIONS
☐ SUBRATE SHEETS

☒ ALL CALCULATIONS
☐ 2 LEVEL PER DEN
☐ 2 LEVEL PER DEN, LTD BY PCT OF CHG
☐ 2 LEVEL SERVICES
☐ 2 LV CASE + EXCESS PCT, LTD BY CHG
☐ 2 LV CASE + PD, LTD BY CHG
☐ 2 LV CASE, LTD BY CHG
☐ 3 LV CASE + PD, LTD BY CHG
☐ 3 LV CASE, LTD BY CHG
☐ 3 LV PER DEN

☐ COMPLETE

STOP LOSS
 IF THE TOTAL CHARGE EXCEEDS \$20,000.00, PRICING IS RECALCULATED TO BE 85% OF THE TOTAL CHARGE.
 THIS CALCULATION WILL BE USED TO REPRICE THE ENTIRE CLAIM WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM. THIS PRICE WILL BE USED IF IT IS THE LAST TERM TO QUALIFY.

OK CANCEL

FIG.19a

25/35

NETWORKX ADMINISTRATION 1.2.6.1 PORT=21000											
FILE HELP											
ROLES	USERS	NETWORKS	EMPLOYERS	PROVIDERS	RATE SHEETS	CONTRACT NETWORKS	CALCULATION CATEGORIES	CODE GROUPS	CLIENTS	ROUTING RULES	MAILBOXES
RATE SHEET:DJWHMC VALID:04-01-1999 THROUGH 12-31-9999 RATE SHEET SEARCH!											
DJWHMC-HARDY MEDICAL CENTER <input type="checkbox"/> PER DIEM <input type="checkbox"/> CASE RATE <input type="checkbox"/> OUTPATIENT SERVICES <input type="checkbox"/> STOP LOSS <input type="checkbox"/> FOOTNOTES		<div> <p>1. PER DIEM</p> <p style="text-align: right;"><u>200</u></p> <p>1.1 MEDICAL CODE GROUP-PER DIEM-MEDICAL. PRICING IS \$750.00 PER DIEM -2,6</p> <p>1.2 SURGICAL CODE GROUP-PER DIEM SURGICAL. PRICING IS \$950.00 PER DIEM. -2,6</p> <p>2. CASE RATE</p> <p>2.1 NORMAL DELIVERY CODE GROUP-NORMAL DELIVERY. PRICING IS A CASE RATE OF \$1,400.00 FOR UP TO 2 DAYS AND \$450.00 PER DIEM FOR EACH ADDITIONAL DAY. LIMIT THE ALLOWED TO THE COMBINED CHARGES. -1,6</p> <p>2.2 CAESAREAN SECTION CODE GROUP-C-SECTION. PRICING IS A CASE RATE OF \$2,800.00 FOR UP TO 2 DAYS AND \$500.00 PER DIEM FOR EACH ADDITIONAL DAY. LIMIT THE ALLOWED TO THE COMBINED CHARGES. -1,6</p> <p>2.3 WELL BABY CODE GROUP-WELL BABY-COMPLEX. PRICING IS 0% OF THE CHARGE. -1,6</p> <p>3. OUTPATIENT SERVICES</p> <p>3.1 ALL SERVICES ALL SERVICES. PRICING IS A 15% DISCOUNT OF THE CHARGE. -1,6</p> <p>4. STOP LOSS</p> <p>4.1 WELL BABY CODE GROUP-WELL BABY-COMPLEX. NO PRICING APPLIES. -1,4,7</p> <p>4.2 STOP LOSS ALL SERVICES. IF THE TOTAL CHARGE EXCEEDS \$20,000.00, PRICING IS RECALCULATED TO BE 85% OF THE TOTAL CHARGE. -1,6</p> <p>FOOTNOTES</p> </div>									
ADD SHEET		CHANGE SHEET		DELETE SHEET		COPY SHEET		ADD ITEM		CHANGE ITEM	
DELETE ITEM		COPY ITEM									
START INBOX MICROSOFT MICROSOFT EXC BFW:ALC-ME EXPLORING-REP JURE NETWORKX NETWORKX 9:06AM											

FIG.19b

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NETWORKX ADMINISTRATION 1.2.6.1 PORT=21000											
FILE HELP											
ROLES	USERS	NETWORKS	EMPLOYERS	PROVIDERS	RATE SHEETS	CONTRACT NETWORKS	CALCULATION CATEGORIES	CODE GROUPS	CLIENTS	ROUTING RULES	MAILBOXES
RATE SHEET:DJWHMC VALID:04-01-1999 THROUGH 12-31-9999 RATE SHEET SEARCH!											
<div> <input checked="" type="checkbox"/> DJWHMC-HARDY MEDICAL CENTER <ul style="list-style-type: none"> <input type="checkbox"/> PER DIEM <input type="checkbox"/> CASE RATE <input type="checkbox"/> OUTPATIENT SERVICES <input type="checkbox"/> STOP LOSS <input checked="" type="checkbox"/> FOOTNOTES </div> <div> <p>2. CASE RATE</p> <p>2.1 NORMAL DELIVERY CODE GROUP-NORMAL DELIVERY. PRICING IS A CASE RATE OF \$1,400.00 FOR UP TO 2 DAYS AND \$450.00 PER DIEM FOR EACH ADDITIONAL DAY. LIMIT THE ALLOWED TO THE COMBINED CHARGES. -1,6</p> <p>2.2 CAESAREAN SECTION CODE GROUP-C-SECTION. PRICING IS A CASE RATE OF \$2,800.00 FOR UP TO 2 DAYS AND \$500.00 PER DIEM FOR EACH ADDITIONAL DAY. LIMIT THE ALLOWED TO THE COMBINED CHARGES. -1,6</p> <p>2.3 WELL BABY CODE GROUP-WELL BABY-COMPLEX. PRICING IS 0% OF THE CHARGE. -1,6</p> <p>3. OUTPATIENT SERVICES</p> <p>3.1 ALL SERVICES ALL SERVICES. PRICING IS A 15% DISCOUNT OF THE CHARGE. -1,6</p> <p>4. STOP LOSS</p> <p>4.1 WELL BABY CODE GROUP-WELL BABY-COMPLEX. NO PRICING APPLIES. -1,4,7</p> <p>4.2 STOP LOSS ALL SERVICES. IF THE TOTAL CHARGE EXCEEDS \$20,000.00, PRICING IS RECALCULATED TO BE 85% OF THE TOTAL CHARGE. -1,6</p> <p>FOOTNOTES</p> <ol style="list-style-type: none"> THIS CALCULATION WILL BE USED TO REPRICE THE ENTIRE CLAIM. THIS CALCULATION WILL BE USED TO REPRICE THE CURRENT LINE. THIS CALCULATION WILL BE USED TO REPRICE THE MATCHING LINE AS A GROUP WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE SMALLEST AMOUNT. WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LARGEST AMOUNT. WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LAST TERM TO QUALIFY. PLEASE NOTE: NO MORE TERMS WILL BE EXAMINED FOR THIS CLAIM/LINE IF IT QUALIFIES UNDER THESE TERMS. </div>											
<div> <div>ADD SHEET</div> <div>CHANGE SHEET</div> <div>DELETE SHEET</div> <div>COPY SHEET</div> <div>ADD ITEM</div> <div>CHANGE ITEM</div> <div>DELETE ITEM</div> <div>COPY ITEM</div> </div>											
<div> <div>START</div> <div>INBOX-MICROS</div> <div>MICROSOFT EX</div> <div>FW:ALC-ME</div> <div>EXPLORING-REP</div> <div>RE</div> <div>NETWORKX</div> <div>MICROSOFT WOR</div> <div>NA</div> <div>11/11/99</div> <div>9:07AM</div> </div>											

FIG.20

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COMPLETED RATE SHEET

MEDICAL CENTER

1. INPATIENT PER DIEM

1.1 MEDICAL

REVENUE CODES IN PER DIEM - MEDICAL. REPRICE AT \$750.00 PER DAY. -2,6

1.2 SURGICAL

REVENUE CODES AND CPT4 PROCEDURE CODES IN PER DIEM - SURGICAL.
REPRICE AT \$950.00 PER DAY. -2,6

2. INPATIENT CASE RATE

2.1 NORMAL DELIVERY 1-2 DAYS

ICD-9 PROCEDURE CODES IN NORMAL DELIVERY. REPRICE AT \$1,400.00 FOR
UP TO 2 DAYS. \$450.00 PER DEIM, THEREAFTER. -1,6

2.2 C-SECTION

ICD-9 PROCEDURE CODES IN C-SECTION. REPRICE AT \$2,800.00 FOR UP TO 2
DAYS. \$500.00 PER DIEM THEREAFTER. -1,6

3. INPATIENT SERVICES

3.1 ALL OTHER INPATIENT SERVICES

ALL REMAINING CODES. REPRICE AT 15% OF CHARGES. -2,6

4. OUTPATIENT SERVICES

4.1 ALL OTHER OUTPATIENT SERVICES

ALL REMAINING CODES. PREPRICE AT 15% OF CHARGES. -2,6

5. STOP LOSS

5.1 STOP LOSS

ALL REMAINING CODES. IF REPRICED AMOUNT EXCEEDS \$20,000.00 THE
CLAIM WILL BE REPRICED AT 85% OF CHARGES. -1,6

FOOTNOTES

- 1- THIS CALCULATION WILL BE USED TO REPRICE THE ENTIRE CLAIM.
- 2- THIS CALCULATION WILL BE USED TO REPRICE THE CURRENT LINE.
- 3- THIS CALCULATION WILL BE USED TO REPRICE THE MATCHING LINE AS A GROUP.
- 4- WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LARGEST AMOUNT.
- 5- WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE SMALLEST AMOUNT.
- 6- WHEN THE CLAIM QUALIFIES FOR MORE THAN ONE TERM, THIS PRICE WILL BE USED IF IT IS THE LAST TERM TO QUALIFY.
- 7- PLEASE NOTE: NO MORE TERMS WILL BE EXAMINED FOR THIS CLAIM/LINE IF IT QUALIFIES UNDER THESE TERMS.

FIG. 21

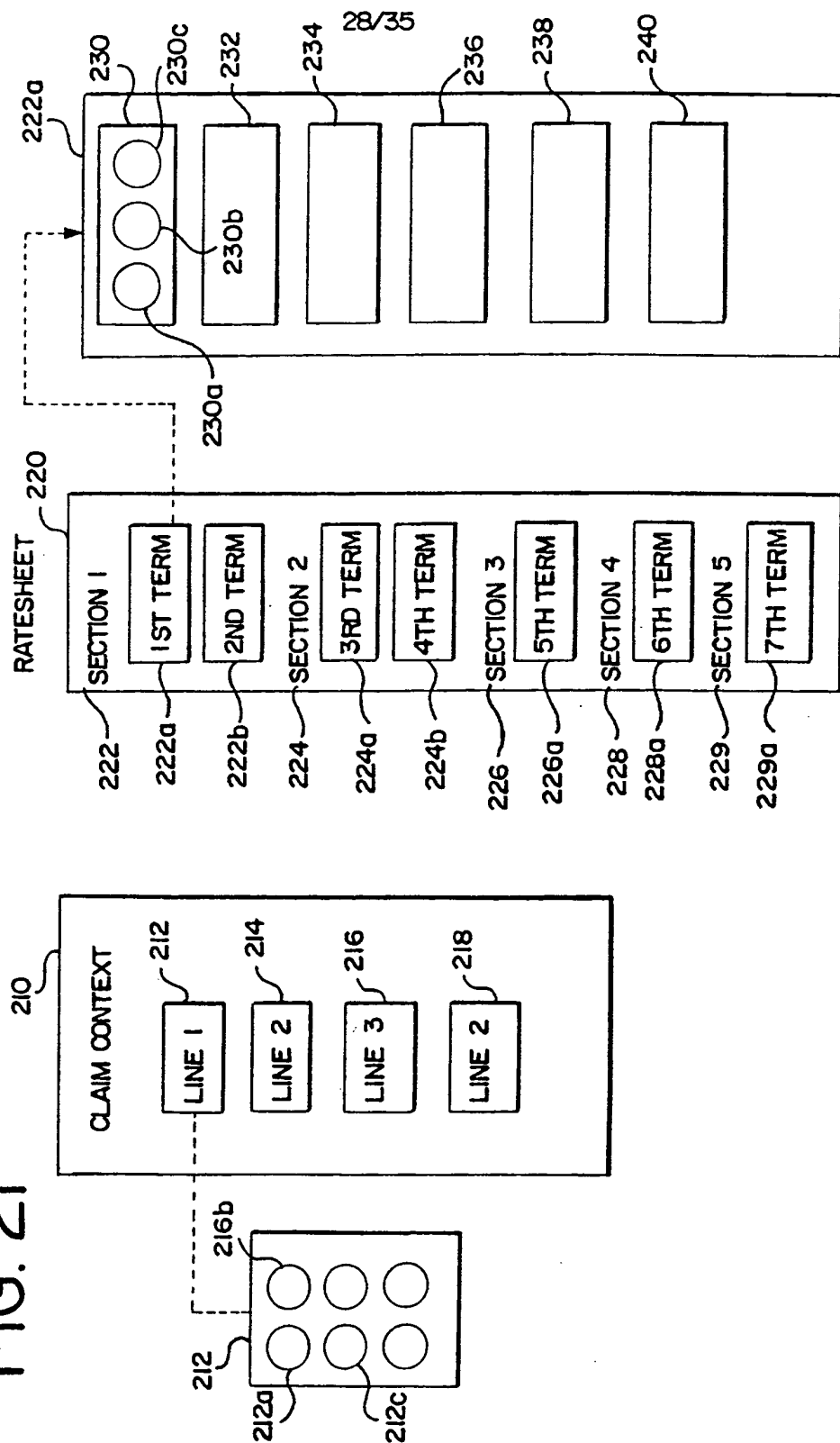
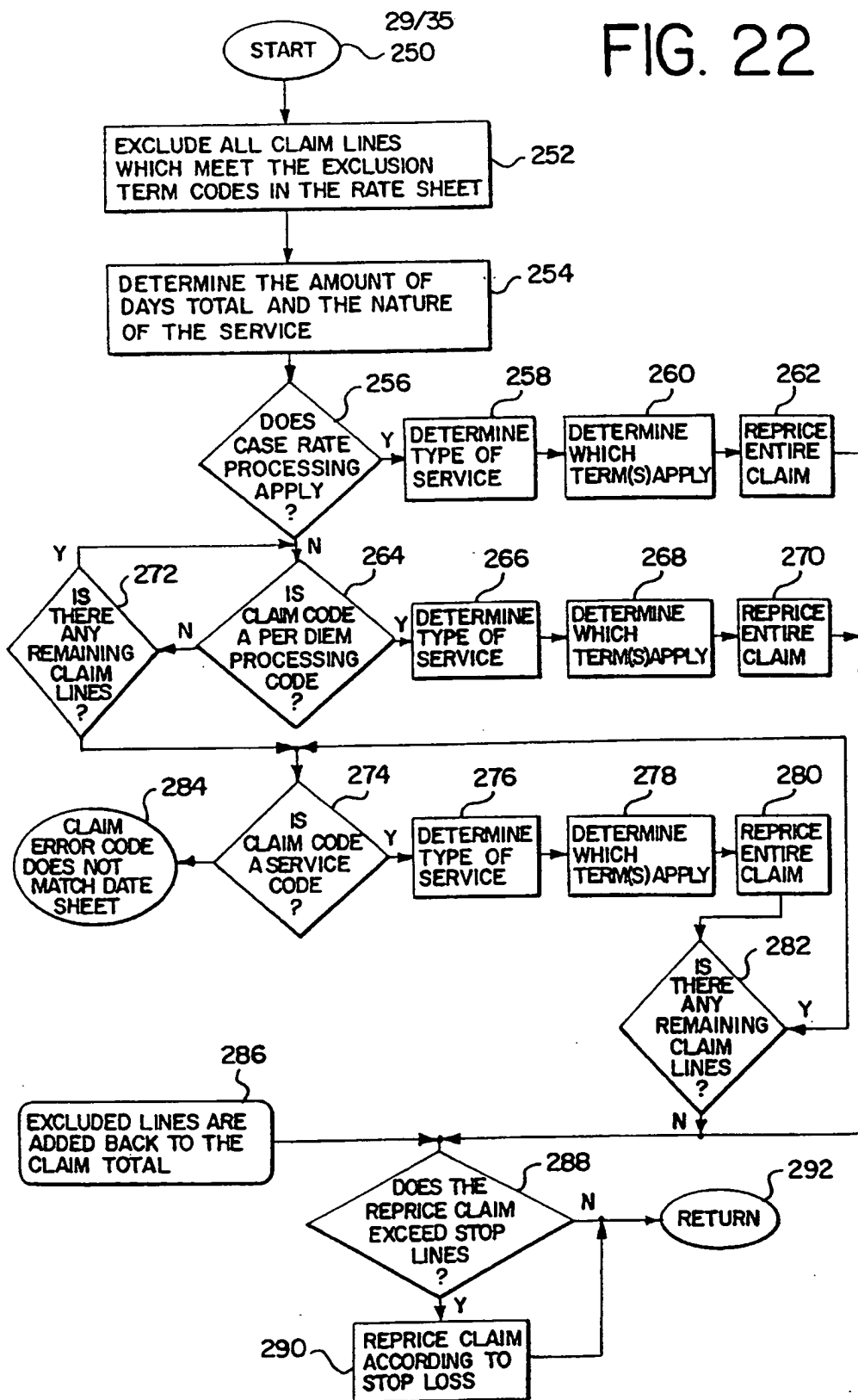


FIG. 22



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FIG. 23

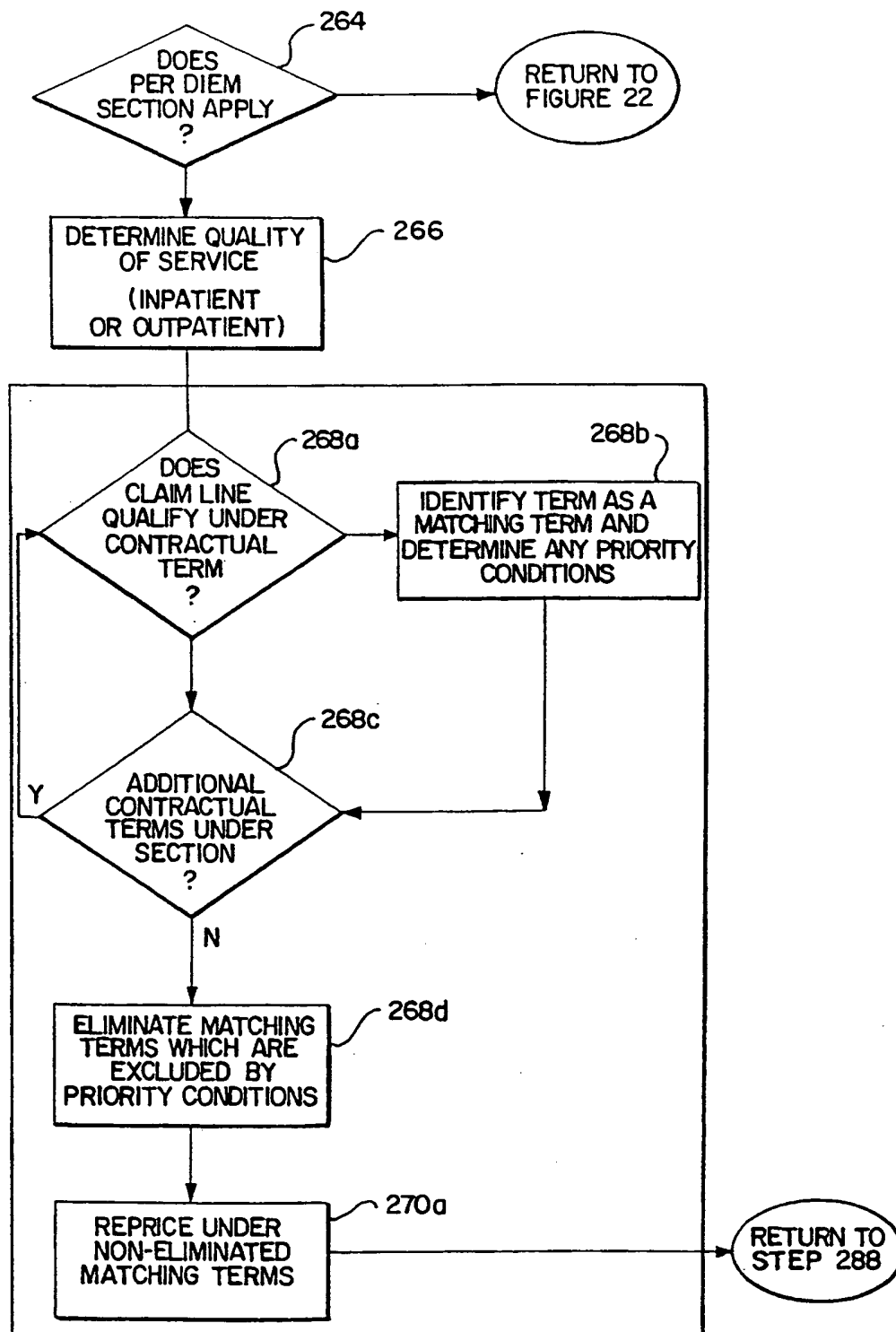


FIG.24

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300

REPRICING WORKSHEET						
PRINT		BACK				
DATE	03/23/2000	PAGE				
WORKSHEET NO	100323CWQXVN					
PROCESSOR	DRNALC					
REPRICING WORKSHEET						
CLIENT/CARRIER: UNICARE LIFE & HEALTH MEMBER EV SLBYAVGDAILY1						
INSURANCE COM						
AUSTIN PAYPOINT (228) MEMBER ID 15						
POST OFFICE BOX 833933 PATIENT DEB NELSON						
RICHARDSON, TX 75083 EMPLOYER EMPLOYER ADVANTAGE						
POLICY NO 130085						
PROVIDER OF SERVICE	HARDY MEDICAL CENTER	PATIENT NO				
TIN	11-9999999	DIAGNOSIS	114			
ADMISSION DATE	01/09/2000	PERIOD:	TO			
REV	DESCRIPTION	UNITS	CHARGE	NOT PRICED	DISCOUNT	NETWORK ALLOWABLE
120	MEDICAL	4	\$20,000.00	\$0.00	\$17,000.00	\$3,000.00
**TOTAL			\$20,000.00	\$0.00	\$17,000.00	\$3,000.00
THE ABOVE WAS REPRICED USING THE AMERICAN LIFECARE NEGOTIATED PRICING.						

OFFICE

MICROSOFT

START END DATE QTR YEAR MONTH DAY TIME NAME 4:06 PM

FIG.25a

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MANUAL CLAIM ENTRY 1.2.6.1 PORT=14400

FILE SEARCH HELP

OFFICE

OUTBOX
ERRORS
PROCESSED
ALL

PATIENT	PROVIDER	SERV DATE	RCVD DATE	SEMTN	NETWORK NO.	CLAIM NO.
DAVE, EXAMPLES	DAVE E. WILLIAMS M.D.	1999-07-12	1999-12-28	DEM	1003220RVLNO	
SUBMAXLOSMAXDISCA, EV	ST MICHAEL HEALTH CARE CENTER	2000-01-09	2000-02-29	EMALC	100322BHMENO	
FRESH SUBMAXLOSMAXDISCA, ...	ST MICHAEL HEALTH CARE CENTER	2000-01-09	2000-03-22	EMALC	100322C2SLVP	

RECEIVED 02/29/2000 CLAIM NO. []

HARDY MEDICAL CENTER

1305 CROWLEY RAYNE HIGHWAY

CROWLEY LA 70526

318-783-3222

3. PATIENT CONTROL NUMBER

4. TYPE OF BILL

6. STATEMENT TAXNO. FROM THROUGH

11-9999999 // //

12. PATIENT NAME

LAST FIRST MI STREET CITY STATE ZIP

NELSON DEB [] [] [] [] [] []

ADMISSION

14. BIRTHDATE 15. SEX 16. ADMISSION DATE 18. HR 19. TYPE 20. SRC

06/15/1957 [] [] 01/09/2000 [] [] [] []

21. CH 22. STAT 23. MEDICAL RECORD NO

24. 25. 26. 27. 28. 29. 30. 31.

32. OCCURRENCE CODE DATE 33. OCCURRENCE CODE DATE 34. OCCURRENCE CODE DATE 35. OCCURRENCE CODE DATE 36. OCCURRENCE CODE FROM THROUGH 37. A B C

38. LAST FIRST MI

39. VALUE CODES CODE AMOUNT 40. VALUE CODES CODE AMOUNT 41. VALUE CODES CODE AMOUNT

42. REV CODE 43. DESCRIPTION 44. HCPCS RATES 45. SERV. DATE 46. SERV. UNITS 47. TOTAL CHARGES 48. NON-COVERED 49. COST

120	ROOM-BOARD/SIM			4	\$4,000.00			
350	CORONARY CARE OR C			1	\$6,000.00			
250	PHARMACY				\$10,000.00			
001	TOTAL CHARGES				\$20,000.00			

Microsoft

PM

START END DATE QTR YEAR MONTH DAY YEAR TIME

4:04 PM

FIG. 25 b

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MANUAL CLAIM ENTRY 1.2.6.1 PORT=14400									
FILE SEARCH HELP									
DATE 10/05/00 TIME 08:00									
OUTBOX	PATIENT	PROVIDER	SERV DATE	RCVD DATE	SBMTR	NETWORK NO.	CLAIM NO.		
ERRORS	DAVE, EXAMPLES	DAVE E. WILLIAMS M.D.	1999-07-12	1999-12-28	DEM	1003220RHLNO			
PROCESSED	SLBYMAXLOSMAVDSCA, EV	ST MICHAEL HEALTH CARE CENTER	2000-01-09	2000-02-29	EMALC	1003220RHLNO			
ALL	FRESH SLBYMAXLOSMAVDSCA, ...	ST MICHAEL HEALTH CARE CENTER	2000-01-09	2000-03-22	EMALC	1003220RHLNO			
50. PAYER 51. PROVIDER NO. 52. REL 53. ASG 54. PAYMENTS 55. AMT DUE 56.									
UNICARE									
57. DUE FROM PATIENT									
INSURED'S CERT-SSN- INSURANCE 58. NAME FIRST MI 59. PREL 60. HIC-ID NO. 61. GROUP NAME 62. GROUP NO.									
SLBYAVG EV 15 EMPLOYER ADVANTAGE 130085									
63. TREATMENT EMPLOYER AUTHORIZATION CODES 64. ESC 65. NAME 66. STREET CITY ST ZIP									
EMPLOYER ADVANTAGE 705 ILLINOIS, #7 JOPLIN MO 64801									
67. PRIN 68. 69. 70. 71. 72. 73. 74. 75. 76. ADM 77. DIAG E-CODE 78.									
760									
79. PC 80. PRINCIPAL PROCEDURE 81. OTHER PROCEDURE 82. ATTENDING PHYS ID									
72									
83. OTHER PHYS ID									
84. REMARKS									
85. PROVIDER REPRESENTATIVE 86. DATE									

FIG.26

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REPRICING WORKSHEET						
PRINT		BACK				
DATE	03/23/2000	PAGE				
WORKSHEET NO	100323CWQXVN					
PROCESSOR	DRNALC					
REPRICING WORKSHEET						
CLIENT/CARRIER: UNICARE LIFE & HEALTH MEMBER EV SLBYAVGDAILY1						
INSURANCE COM						
AUSTIN PAYPOINT (228) MEMBER ID 15						
POST OFFICE BOX 833933 PATIENT DEB NELSON						
RICHARDSON, TX 75083 EMPLOYER EMPLOYER ADVANTAGE						
POLICY NO 130085						
PROVIDER OF SERVICE	HARDY MEDICAL CENTER	PATIENT NO				
TIN	11-9999999	DIAGNOSIS	780			
ADMISSION DATE	01/09/2000	PERIOD:	TO			
REV	DESCRIPTION	UNITS	CHARGE	NOT PRICED	DISCOUNT	NETWORK ALLOWABLE
120	MEDICAL	4	\$20,000.00	\$0.00	\$17,700.00	\$2,300.00
**TOTAL			\$20,000.00	\$0.00	\$17,700.00	\$2,300.00
THE ABOVE WAS REPRICED USING THE AMERICAN LIFECARE NEGOTIATED PRICING.						

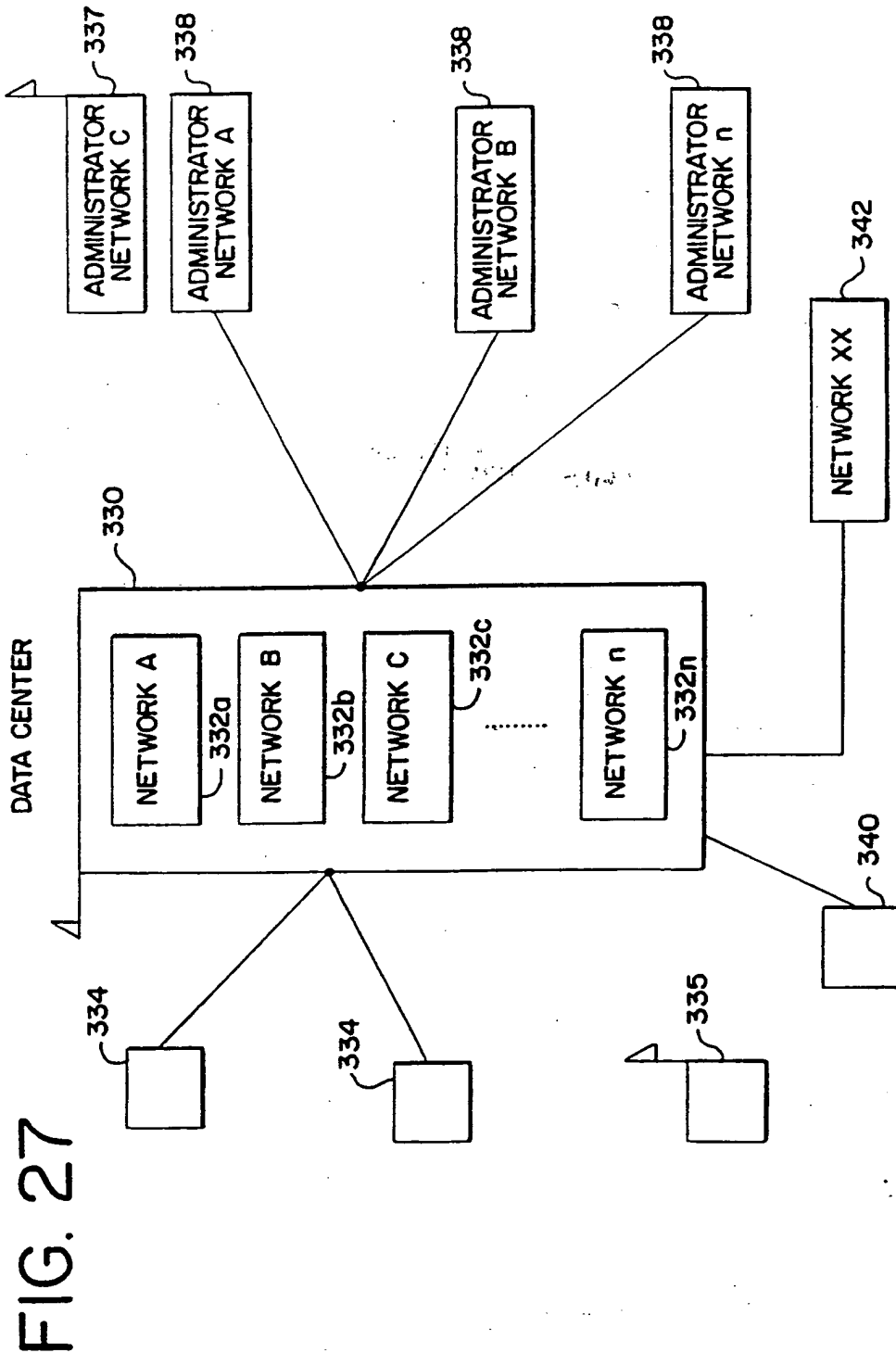
OFFICE

NETWORK NO. CLAIM NO.

MICROSOFT

START END COPY PASTE FIND REPLACE VIEW HELP MICROSOFT WORD 4:10 PM

35/35



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